PHILADELPHIA, SEPTEMBER 22, 1883.

ORIGINAL LECTURES.

CLINICAL LECTURE.

A CASE OF EPILEPTIFORM CONVULSIONS, ACCOMPANIED BY GREAT ENLARGEMENT OF THE LIVER AND SPLEEN, DUE TO TERTIARY SYPHILIS—THE POST-MORTEM RESULTS IN A CASE OF RHEUMATISM COMPLICATED BY PERICARDITIS, ENDOCARDITIS, AND PLEURISY—THE AUTOPSY OF A CASE OF INTRACRANIAL TUMOR.

Delivered at the Pennsylvania Hospital

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A CASE OF EPILEPTIFORM CONVULSIONS, ACCOMPANIED BY GREAT ENLARGEMENT OF THE LIVER AND SPLEEN.

GENTLEMEN,—The first patient whom I bring before you this morning gives us the following history: S. H., age 37, born in England, single, a machinist by occupation. His father, mother, brothers, and sisters are living and healthy. In 1865 he had an attack of intermittent fever lasting two weeks. He had a second attack in 1870, since which time there has been no return. In 1865 he had an attack of jaundice; in 1866 he contracted a chancre, which was followed by secondary symptoms. With these exceptions, he had good health until three years ago, when he had a convulsion. Since then he has been subject to convulsive attacks, which recur at intervals of from one to three weeks. These come on suddenly without warning, are accompanied by loss of consciousness, and are followed by sleep.

About three weeks ago he observed a swelling of the abdomen; he felt weak and miserable, his appetite failed, he lost flesh, and was obliged to quit work. He states that during the past few months he has passed large quantities of water,—as much as two gallons during the twenty-four hours. We have nothing but his statement for this, and it is doubtful that the amount is as great as this. He has always been of temperate habits.

He was admitted December 15, 1882. On admission he was found to be anæmic and jaundiced; the appetite poor; bowels regular; liver and spleen found enlarged; pain in the splenic region; no œdema.

December 16, the urine for the past twenty-four hours was measured and found to be fifteen pints. Its specific gravity was 1010. Neither albumen nor sugar was present.

December 24, he had two convulsions two hours apart. As the attacks came on he made a great deal of noise and struggled; during the convulsions his face was very much congested.

December 25, another convulsion; not so severe. Passed six pints of urine.

January 7, great deal of nausea; diarrhœa. Another convulsion. Was ordered

Acid. carbolic., gr. $\frac{1}{4}$;
Morph. sulph., gr. $\frac{1}{24}$. M.

To be repeated every four hours.

January 8, another convulsion. Was ordered bromide of potassium three times a day.

January 31, has not had another convulsion; otherwise his condition is much the same.

He had two convulsions last night (February 6).

There is in this case a history of two diseases which are very likely to leave more or less permanent effects. There is, in the first place, a history of malarial poisoning which occurred a number of years ago and then recurred in 1870, since which time he says that he has had no chills. In the second place, there is a history of syphilitic poisoning in 1866. This was followed by unmistakable secondary symptoms,—sore throat, loss of the hair, pains in the bones, etc.

Finding this history of repeated convulsive seizures, I proceeded to make an ophthalmoscopic examination. On introducing a solution of sulphate of atropia to dilate the pupil, I found that while one pupil dilated quickly and regularly, the other at first did not dilate, and when it did it was in an irregular way. In the left eye there are adhesions preventing the lower part of the pupil from dilating. This, which is the result of iritis, is another proof of the syphilitic infection. There is also on this man's head a node, which he discovered three or four weeks ago, but which has probably existed for a much longer time.

Having shown you this much, I shall next proceed to demonstrate the condition of his spleen and liver. You will recollect that the notes say that there is great enlargement of the spleen and liver. It appears that the swelling of the abdomen has been only observed for a short time past; but I think, as I did in regard to the node, that it has existed for a much longer time. In patients belonging to this class of life, symptoms which do not positively interfere with labor are rarely noticed.

I find in the left hypochondriac region a tumor. This extends down in the line of the nipple to the level of the umbilicus; indeed, it goes a little below it, and extends to within an inch and a half of the median line. Posteriorly it is lost behind the ribs, and the muscles are so tense that I cannot get at its borders. It descends a little with respiration. I shall show you that the dulness of this tumor is continuous with that of the spleen. In determining the boundaries of the spleen by means of percussion, the patient should be turned half-way on his side. The percussion-note is dull all over this region until I reach the lower border of the tumor, when I obtain a clear sound due to the presence of intestines.

From this examination there can be no doubt that there is great enlargement of the spleen. This has probably existed for a great many years, and is, I think, due to the first of the diseases to which I have referred, or to the first in connection with the second. This enlargement is not infrequently seen in malarial poisoning. Before the disease was treated as promptly as it is now, this condition was seen far more frequently; but scarcely a term of service which I have spent in this hospital during the past fourteen or fifteen years has passed in which I have not seen a case of splenic enlargement due to malarial poisoning.

Splenic enlargement is not all that we have. As the patient lies on his back you can see that the right hypochondriac region is quite prominent. This is more marked below the ribs in front than it is laterally. The hepatic dulness begins just below the line of the nipple, and extends some distance below the margin of the ribs. There is enlargement of the liver, but it is not symmetrical: I find that it is most marked in the anterior region. We have now to account for the hepatic enlargement. There may, of course, be an increase in the size of the liver from the same cause (malarial poisoning), but in all the cases dependent on this cause which I have seen, the liver has been uniformly enlarged. In this man the enlargement is more prominent in one region than in another. I am inclined to attribute this to the syphilitic poison. Syphilitic enlargement of the liver is frequently irregular.

Let me next speak of the convulsions. These are probably due to syphilitic disease of the brain. What the exact character of the disease is I am not prepared to say. We, however, know that syphilitic disease frequently gives rise to convulsions, while on the other hand malarial poisoning does not do so to any great extent. I have, however, seen convulsions occur once or twice during the chill. In these cases there must have been some predisposition to convulsive seizures, for this complication is very rare. In this case there may be a node upon the internal surface of the skull, or there may be disease of the membranes or disease of the brain itself. The most probable of these is the formation of a node.

I now turn to the treatment. The indications are various, and, to a certain extent, at variance one with the other. We have malarial poisoning and syphilitic poisoning, and we have the results of the two diseases to treat. The symptoms due to syphilis seem to be the more prominent, and those which require treatment at the present time. This patient should be placed on the iodide of potassium in large doses. I should not give it in five-grain doses, but in thirty-grain doses three or four times a day. If the convulsive seizures did not diminish in frequency under this treatment, I should push it still further. There is, of course, a doubt whether such large doses are absorbed, but where life is in danger from the syphilitic poisoning I think that it is better to run the risk of giving more than can be absorbed than to give less than might be absorbed. It might be thought to be proper to treat the epileptiform convulsions, but I think, as they are due to syphilitic disease of the brain, they will be relieved by the iodide of potassium. We know, however, from the history of the case, that the bromides have been of service; there is, therefore, no objection to continuing this remedy in proper doses. In such a case I should be, however, more

disposed to rely upon the iodide than upon the bromide of potassium.

The man has also enlargement of the spleen, due to malarial poisoning; but, as there are no chills, quinia is not necessary. The injection of five grains of ergotin dissolved in a small quantity of water into the tissues over the spleen twice a day will, I think, prove of service. I do not know that there is any special advantage in injecting it over the spleen, but this is the usual place for doing it. It has been recommended to inject ergotin or iodine into the substance of the organ, but I should hesitate to resort to this unless the indications were much more marked than in the present case. There is always risk in these injections of producing inflammation and subsequent peritonitis. The injection of ergotin into the tissue over the spleen does not often give rise to abscess, and the liability to abscess may, I think, be in great measure avoided by painting the part where the injection is made immediately afterwards with tincture of iodine.

The prognosis is, I think, on the whole, favorable. I do not know of any class of cases which do better under treatment than do those of syphilitic disease. As the patient is not entirely broken down, there is reason to hope for considerable improvement.

You might ask if it would not be well to give some preparation of mercury. I think not. In tertiary syphilis mercury often does more harm than good. I sometimes add to the iodide of potassium a little bichloride of mercury, which is the least objectionable of all the mercurial preparations. I do this only when syphilis is passing from the secondary to the tertiary stage. Under these circumstances it is sometimes a useful addition.

THE POST-MORTEM RESULTS IN A CASE OF RHEUMATISM COMPLICATED BY PERICARDITIS, ENDOCARDITIS, AND PLEURISY.

Among the patients in the ward, when I took charge of it a few days ago, was a young man suffering from an unusually severe attack of rheumatism. Not only did it affect many of the joints, but when I took charge of him there were also well-marked evidences of pericarditis. The patient did fairly well for a day or two, and the joint-affection even seemed to subside for a time. Unfortunately, this improvement was only temporary, and in a short time there was a recurrence of high temperature and an exacerbation of the cardiac symptoms.

The treatment was that which is usually employed in this house,—*i.e.*, salicylate of sodium in large doses frequently repeated. In addition to this remedy we also gave, in consequence of the cardiac complication, digitalis, and at different times opium in the form of Dover's powders. To relieve the pain, the patient, as I have said, after doing fairly well for a short time, became worse, and on Sunday died.

The physical signs which clearly revealed the presence of pericarditis were, in the first place, friction-sounds. When, under ordinary circumstances, we listen over the præcordial region, no sound is heard from the two surfaces of the pericardium gliding over each other; but, even if this membrane become dry, there will be a grazing sound, simple dryness being sufficient to give rise to a slight sound. If inflammation occurs and exudation takes place, there will be a rubbing sound which differs in its character entirely from the endocardial murmurs. The endocardial sounds are blowing, the exocardial is rubbing. The latter may be heard all over the heart. They have a to-and-fro character. In some instances there is but a single murmur produced by friction. It is at times difficult to distinguish between such a murmur and an endocardial sound; but usually, by careful attention to a few points, the diagnosis may be made. Endocardial sounds correspond either with the systole or the diastole of the heart, and are therefore heard with the first or second sound; exocardial sounds are apt to occur between the cardiac sounds. The endocardial sounds are propagated to a great distance from the heart; exocardial sounds are heard only over the region of the heart.

There was in this case, in addition to the friction-sound, some dulness on percussion at the base of the heart. The sound obtained by percussing over the second intercostal space of the left side was much duller than that obtained in the same position on the right side. When effusion takes place, the pericardial sac is usually first distended at its upper part: you should therefore always look for a slight amount of effusion in this region. The fact that a friction-sound could be heard showed us that the quantity of effusion was not great, for if the amount of liquid were great, the two surfaces of the pericardium could not come

in contact, and no sound would be produced.

I now ask your attention to the examination of the heart, which we removed at the autopsy. You see all over its surface the evidences of exudation: this appearance has been compared to that of a beef's tongue. The amount of effusion was very small; part of the dulness heard at the base of the heart was probably therefore due to infiltration of the pericardium. A few adhesions uniting the two layers of the pericardium were also found.

I forgot to mention, while speaking of the cardiac sounds, that on listening very carefully I also heard an endocardial murmur. This had very little intensity: it was only by a careful examination that it could be recognized. There are here evidences of slight inflammation of the endocardium, which should account for this sound.

This patient was also the subject of pleurisy; in fact, it is probable that the pericarditis alone would not have been sufficient to kill him. He had on one side pleurisy with effusion. The embarrassment of the respiration due to the effusion, added to the embarrassment of the circulation, was the cause of death. An examination during life revealed dulness on the right side, but it gave the patient so much pain to disturb him that, after determining the presence of effusion, I did not continue the examination further. Here is the right lung, which presents an appearance similar to that of the pericardium. There is a deposit of fibrin on the pleural membrane; the left lung was adherent to the sides of the chest.

In making a careful post-mortem, Dr. Morris Longstreth found the mesenteric and intestinal glands slightly calcareous. This man had typhoid fever ten years ago. This is interesting, as it gives us the opportunity of examining the condition of the glands several years after the attack of typhoid fever. I here show you some of the glands in this condition. I do not think that these could have ulcerated, for I do not see any cicatrices.

The post-mortem in this case reveals, then, well-marked pleurisy, well-marked pericarditis, slight endocarditis, and the evidences of old disease in the intestines.

THE AUTOPSY OF A CASE OF INTRACRANIAL TUMOR.

You may recollect that on at least two occasions during the past few months I showed you a patient from the female medical wards, who had a tumor on each side of the neck, with a protuberance of the left eye, and paralysis of almost all the cranial nerves of that side. The olfactory and optic nerves did not seem to be involved; there was paralysis of the parts supplied by the third, fourth, fifth, sixth, seventh, and eighth nerves of the left side; the muscles moving the tongue were not affected: it was therefore probable that the hypoglossal nerve was not involved. The pneumogastric also escaped, for there was no interference with respiration or with the action of the heart.

When I first saw the patient, six months ago, with my colleague, Dr. Arthur Meigs, she presented a very different condition from that which she did when you first saw her. The most prominent symptom at that time was supra-orbital neuralgia. The paralysis which I have mentioned did not at that time exist, or, if it did, only to a slight degree. I attempted to make an ophthalmoscopic examination, but found the iris so adherent that it was impossible for any but an expert to obtain a good view of the fundus. In addition to the adhesions, there were opacities of the cornea. At my request, Dr. Harlan made the ophthalmoscopic examination, but found no choked disk. There seem then to have been no evidences of interference with the circulation of the brain.

When I took charge of her there was paralysis and intense pain, and the existence of a tumor on the right side of the neck, which to a certain extent rendered the diagnosis clear. It seemed not improbable that if there were a tumor outside of the skull there might also be one inside causing the paralysis and neuralgia. It at first seemed likely, in consequence of the iritis and the irregularity of the patient's past life, that the disease might be specific; but upon a more careful investigation and a more thorough study of her history there appeared to be no good ground for this supposition. A few weeks after I took charge of her, a second tumor began to appear on the left side of the neck. This was very painful to the touch, and increased rapidly in size. The presence of these tumors furnished important evidence as to the character of the disease within the skull.

The next point was to determine the seat of the intracranial disease. This we

were enabled to do by a careful study of the symptoms. Finding the parts supplied by the nerves which I have indicated paralyzed, we of course concluded that the disease must be situated at a point where it would involve these nerves. This point must be in the neighborhood of the petrous portion of the temporal bone. Most of the nerves implicated either originate from the brain or pass from the skull at this point. The question as to whether the disease sprang from the bone or from the membrane could not, I think, have been answered during life. If syphilitic, or if cancerous, it might come from either: there were no evidences of disease of the bone or of the membrane. The patient died a few days ago.

At the autopsy it was found that the disease was situated exactly at the position where we had expected to find it. I have here the petrous portion of the temporal bone, with a portion of the sphenoid bone of the left side: there is here a tumor as large as a walnut. As I have said, there were no signs of affection of the optic nerves during life; after death they were found to be a little flattened, but they did not pass through the tumor, and were not diseased; neither were the olfactory bulbs pressed upon. The hypoglossal and pneumogastric nerves are given off so far back that they escaped: if there was any impairment of vision, it was exceedingly slight, but all that could be detected might be explained by the opacity of the cornea.

The tumor pushed the brain slightly towards the opposite side, but it did not extend beyond the median line; the left eyeball was so prominent (preventing the closing of the eyelids) that we at one time suspected that a tumor was developing within the orbit; but none has been found. We have not had time to examine these growths under the microscope, but this will be done.

The post-mortem in this case very thoroughly explains the paralysis noted during life.

INODOROUS IODOFORM.—The peculiar odor of iodoform is found to be well masked by the addition of attar of rose, one minim to the drachm, or of essence of rose geranium, three or four minims to the drachm. The clinic-room gets to smell like a florist's shop. —*Polyclinic.*

ORIGINAL COMMUNICATIONS.

CATARRHAL PNEUMONIA IN INFANTS AND OLDER CHILDREN.

BY E. T. BLACKWELL, M.D.

PATHOLOGISTS have in recent years divided the disease formerly known as pneumonitis, pneumonia, and inflammation of the parenchyma of the lungs, into two separate disorders, each of which has its seat in the structure of the air-vesicles, and affects, in varying degrees, the blood-vessels, nerves, and connective tissue so intimately connected therewith. Both forms have some associated bronchitis, and, if situated near the surface of the lungs, pleurisy more or less severe. They differ from each other in the manner of their invasion, in the type of their fever, in the character of the effused product, and in the physical signs which arise in their progress.

One division, which answers to the classical pneumonia of most authors, invades the alveoli, causing therefrom a plastic exudation with both red and white corpuscles, and is called croupous pneumonia. The other affects the same anatomical structure, but its exudate lacks the plastic character and red color of the first, and soon degrades into pus. Since it occurs as a sequel to catarrh and to eruptive diseases in which catarrh is a conspicuous element, it is called catarrhal pneumonia. The two have many leading symptoms in common, which vary in extent and degree. These are fever, rapid breathing with great change in its ratio to pulsation, pain, cough, expectoration, and a bluish hue of the skin and mucous membranes.

The fever in croupous pneumonia is marked by evening exacerbations and morning remissions, the extremes of temperature standing at about 105° and 102° Fahr. Should the pleura be involved, the pain may be considerable, and cause the patient to restrain the movement of the ribs as much as possible by lying on the affected part; if otherwise, the pain is insignificant or absent, the patient lying upon the back or indifferently. Expectoration, if present, is scanty, consistent, tenacious, and intimately mixed with blood. Percussion, at first slightly tympanitic, soon loses this character, and runs through all the shades of dulness to that indicating complete consolidation. The respi-

ratory murmur, little changed at first, soon is marked on inspiration by a fine crepitant râle. The bowels are generally constipated, and there are the usual secretory disturbances attendant on pyrexia.

Catarrhal pneumonia has no regular type of fever; its diurnal variations are irregular, the maximum occurring sometimes in the morning, sometimes at night. In the pneumonia of measles the temperature may reach 105.5° Fahr., and continue for days with but slight remissions, the pulse remaining frequent even after the temperature has fallen. In children, who furnish the most of the cases, the rate is often extreme, so frequent as scarcely to admit of counting. There is moaning and crying. The expectoration is whitish, frothy, and diffluent. Both inspiration and expiration are from the outset accompanied by a mucous or subcrepitant râle derived from the catarrh of the bronchioles. In the progress of the disease it may become a crepitant râle, as in the other variety. The percussion, somewhat dull at first over the collapsed portion of the lungs from absence of air, becomes decidedly so in the later stages from effusion into the air-cells. The upper or unaffected portion of the lungs is tympanitic throughout the disease. Joergensen, whose description I have followed, among the symptoms of the catarrhal variety does not reckon changed ratio of respiration and pulse, which is made so prominent in his description of croupous pneumonia. If I am correct in the diagnoses of the cases appended to this paper, it will be seen that the departure from the normal ratio in this form is also very remarkable. The inflammation includes the bronchial tubes of all calibres in the catarrhal, and may even seize upon the trachea and larynx; in the croupous the bronchioles only are involved.

The differential diagnosis, scarcely possible in many cases, is perhaps not greatly important in a therapeutic point of view. In both we have to resist the same forces, fever and inflammation. We shall attack them simultaneously,—the local development by revulsives, and the fever by the usual antipyretics. In open and sthenic cases the therapeutical means at our command are equal to the cure of the diseased condition; in the asthenic we may find all remedies, especially all lowering forms of treatment, utterly barren of good results.

In the *Philadelphia Medical Times*, vol. x., I reported a short series of cases of pneumonia of an adynamic form, submitting the view of Joergensen that such cases might be true examples of infectious fever with a low type of local development in the lungs. Antipyretics and revulsives were useless, in these cases, to change the morbid action or check the march to dissolution.

Our German friends, who have labored faithfully to establish the individuality of the two forms of pneumonia, have afforded us little help in the way of treatment. Their suggestions on prophylaxis and hygiene are sound, but their great weapon, the cold bath, needs to be used with great caution, and is dangerous except there be constant and skilful supervision and watchful intervention. At private houses these essentials are not attainable. The things condemned by them include both good and bad measures. Among the latter, that known as the contra-stimulant treatment—the saturation of the blood with tartrate of antimony—should meet the hearty reprobation of all judicious physicians, but their banishment of blisters deprives their patients of a certain means of relief, if used early and effectually. The decoction of senega, extolled by them, should be made to give way before the mixture of myrrh, a drug imparting great tone to the mucous membrane, the relaxed condition of which the former rather intensifies and fixes. It is, besides, nauseous and disagreeable to more than one of the senses. When we mark the result of their practice, we shall not be greatly encouraged to try it upon our patients. Bartels lost, in catarrhal pneumonia, all under one year; after that period one-third. Ziemssen lost one-half under the age of one year; from one to three years old, about two-fifths; in the later years, only one-fourth.*

Outside the cases already reported, and two others beyond the age of vigor in which the treatment of Rasori was used with unfavorable results, my experience has included a few cases happening in early adult life, and many children, especially infants of the first and second year. During the last thirty years, in which I have used the treatment detailed below, recovery has been the rule. When called to attend the tenderest infant with quick

* Ziemssen's Cyclopædia, vol. v. p. 222.

respiration, a short, suppressed cough, and fever, I placed immediately upon the chest either a mustard-poultice to be used perseveringly or a blister to the whole surface, following the outline of the thorax. Appropriate internal means were used in connection. The crepitant râle, if not heard at the first visit, was sure to set its seal to the correctness of the diagnosis. The following, from their mode of invasion, symptoms, and general behavior, are believed to be examples of catarrhal pneumonia, although, if paroxysmal fever and rapid breathing be peculiar to croupous pneumonia, they cannot be separated from that variety. The gravity of the cases and the success of the treatment may be deduced from a study of these examples:

Case I.—Bertie B., a robust child of 22 months, residing in Philadelphia in a house used partly as a stable, about and beneath which manure was constantly fermenting, was taken, January 18, 1882, with catarrh, which presented no characteristics worthy of note. For this she was ordered a potash mixture uniting diaphoretic, expectorant, and anodyne qualities. In a day or two, the patient being more restless, but otherwise apparently unchanged, the anodyne was increased. The affection continued mild until the morning of the 21st, when urgent symptoms of embarrassed breathing occurred, the respirations reaching 100 and the pulse 120 per minute (the ratio being 10 : 12). A crepitant râle was found in both lungs. A plaster of cantharidal cerate was applied to the front of the chest, limited above by the clavicles, below by the edge of the costal cartilages, and laterally by a line dropped from the anterior fold of each axilla. The following mixture was ordered:

℞ Potassii citratis, ℥ss;
Ext. digitalis fl.,
Ext. ipecac. fl., āā ♏v;
Ext. aconiti fl., gtt. iii;
Tinct. opii camphoratæ, ℥vi;
Ext. glycyrrhizæ fl., ℥j;
Syrupi,
Aquæ, āā ℥ss.

M. S.—A teaspoonful to be taken every two hours.

9 P.M.—The cerate has caused a satisfactory blister; the serum has been properly evacuated, and the surface dressed with a fomentation. The respirations have fallen off nearly one-fourth in point of frequency, the range being from 72 to 86 per minute, while the pulse remains as before,—122 (ratio, 7 : 12).

22d, 9 A.M.—Respirations vary from 72 to 66 per minute. The iodide and bicarbonate of potassium were added to the prescription for their higher alterative and reducing power upon the crasis of the blood, and syr. acaciæ substituted for the simple syrup.

January 23, 9 A.M.—Respiration 54; other symptoms unchanged. 5 P.M.—The pulse, while having about the same frequency as before (122), is much less strong. The patient clutches at the face and moans. The bowels are closed. To take the following:

℞ Elixir calisayæ,
Elixir ammonii valerianatis,
Spt. ætheris nitrosi, āā ℥j;
Ext. belladonnæ fl., gt. j;
Ext. scillæ fl., ♏v;
Ext. glycyrrhizæ fl., ℥i;
Ol. cajuputi, gt. j;
Syr. acaciæ, ℥j. M.

S.—A teaspoonful every two hours.

8 P.M.—The pulse is fuller and quicker,—132. The respirations have remounted to 70 (ratio, 7 : 13). Treatment continued.

January 24.—The patient has rested well, the fever passing away in the night. The cough and expectoration are easy, the urine abundant. Respiration 56; pulsations 120 (ratio, 5.6 : 12). To take, in addition to former remedies, a teaspoonful of aromatic syrup of rhubarb every four hours. 8 P.M.—The breathing is quicker; there is a troublesome, rather spasmodic cough and fever. The cantharidal plaster, already described, is to be divided vertically, and each half is to be applied beyond the edges of the surface already blistered so as to include the area defined by the outer edges of the scapulæ.

January 25, 8 A.M.—A good blister was obtained in three hours, which was dressed as before. There was some delirium after midnight. She is now resting well, with a pulse at 120 and respiration 50 (ratio, 5 : 12). She has had one movement of the bowels. The urine is scanty. Directed:

℞ Quiniæ sulph., gr. iv;
Pulv. ipecac.,
Pulv. opii, āā gr. jss;
Pulv. caffeæ Arab., gr. xii.

Mix, and divide into twelve powders, one to be taken every three hours, alternately with the mixture. 8 P.M.—Respiration 53, pulse 120. There have been two movements of the bowels, and a free ejection of mucus. The rhubarb syrup is to be discontinued.

January 26.—The patient was restless during the fore part of the night, but in the after part she slept well, having no fever. 6 P.M.—She is doing well.

January 27.—The patient's face is somewhat flushed; pulse 125, respiration not noted. She has had one alvine evacuation, slimy and offensive. In the place of the former powders she is to take the following:

℞ Quiniæ sulph., gr. ii;
Hydrargyri c. cretæ,
Pulv. ipecac.,
Pulv. opii, āā gr. j.

M. et ft. chart. no. viii.

S.—Let one be taken every four hours, alternating with the following mixture:

℞ Spt. ætheris nitrosi,
Elixir calisayæ, āā ʒj;
Ext. belladonnæ fl., gt. j;
Ext. scillæ fl., gtt. viii;
Ext. glycyrrhizæ fl., ʒj;
Ol. cinnamomi, gt. j;
Syr. acaciæ, ʒv.—M.

Dose, a teaspoonful.

January 28.—The patient has rested well, coughing less. The face, while she sleeps, is flushed. Pulse 129; respiration not noted. The tongue is somewhat coated; there has been a gentle perspiration. The quinia is to be increased to a half-grain every four hours, the other medicine to remain unchanged. I also ordered the following:

℞ Iodini,
Ol. amygdalæ amaræ, āā gr. iii;
Ung. petrolei, ʒj.

Let the iodine be rubbed with the oil, and when reduced add the cosmoline.

S.—Apply externally.

4 P.M.—The patient has sweated considerably, and there has been a more natural evacuation of the bowels. The treatment is to be continued.

January 29.—The patient has a severe cough, but has slept well. The pulse is 118; the bowels regular and natural.

January 30, 9 A.M.—The patient has rested well, but the cough is rather violent and paroxysmal, approaching a whoop. The following was prescribed for the lung-indications, the myrrh in particular assisting in expelling the mucus from the bronchial tubes and giving tone to their lining membrane:

℞ Myrrhæ opt., gr. xvi;
Potassii iodidi, gr. iv;
Elixir ammonii valerianatis, ʒii;
Ext. belladonnæ fl., gtt. xii;
Ext. scillæ fl., ♏v;
Ext. glycyrrhizæ fl., ʒj;
Infus. caffeæ Arab., ℥jss.

Rub the salt with the myrrh and a very little of the infusion to a smooth paste, adding thereafter the remaining ingredients.

S.—A teaspoonful every four hours.

January 31.—There has been but one hard paroxysm of coughing attended by a whoop. The bladder is acting well, as also the bowels, the dejecta being, however, still slimy. The appetite is improving. She is to take one-fourth grain of quiniæ s. with one-half grain of powdered coffee every four hours.

February 8.—Although left as convalescent at the time of the last record, the patient has continued weak, a catarrhal condition of the bowels causing from eight to ten movements yesterday. I ordered the following:

℞ Bismuthi subcarb., ʒj;
Hydrarg. c. creta, gr. vj;
Ext. ipecac. fl., ♏x;
Tinct. opii, fʒj;
Glycerinæ, fʒiii;
Ol. cinnamomi, gtt. j;
Aq., ℥iiss. M.

Sig.—Give a half-teaspoonful every two hours, increasing the dose if necessary.

February 18.—The cough persists, and the bowels are irritable. Let the myrrh mixture be continued, the iodide of potassium being exchanged for chlorate of ammonia and elixir pepsin and bismuth for elixir valerianate of ammonia, the dose to be a teaspoonful three times a day. From this time convalescence steadily progressed to complete recovery.

Case II.—Walter T. H., 13 years of age, farmer's son, residing in Warren County, N. J., was taken with measles about April 18 last. He had a high fever and a tardy eruption. During the forenoon of Friday, April 20, he coughed almost incessantly; in the afternoon the cough subsided, but the fever increased and the respirations became very rapid. At 9.30 A.M. of the 21st they reached 60 per minute, varying but little from that figure during the day. No pain was complained of. At 9 P.M. of that day I saw him for the first. He lay upon his back, with his knees drawn up. There was a heaving impulse connected with the breathing, which was at the rate of 40 per minute; pulse 130 (ratio, 4:13). There was an abundant rash about the body and thighs; the temperature was a trifle over 104° Fahr.; there was a fine crepitant râle in the lower lobe of the right lung, and a few scattered coarse ones in the left; the skin was hot and dry, the tongue slightly coated, and the bowels were moving frequently. He was given immediately a powder composed of quinine, opium, and ipecac, and perspiration soon appeared upon the face and forehead. A blistering plaster of a hand's-breadth was ordered to be placed upon the front of the chest, to reach from scapula to scapula and to conform below to the free edge of the ribs and costal cartilages. This was applied at 1 A.M. April 22, and was constantly moistened with tinct. camphoræ. At 11.30 A.M. it was removed, having been applied ten and one-half hours. Beneath the loosened cuticle a small amount of serum had collected, which was evacuated, and a poultice of bread-crumb and warm water was applied as a dressing, the heat and moisture being retained by a covering of flannel and oil-cloth. The respiration had now fallen to 28, and the pulse to 120 (ratio less than 3:12). The crepitation was greatly lessened. 3 P.M., respiration 24, pulse 84; 7 P.M., the fever has returned, the skin being very hot, and the pulse marking 125. He coughs and raises some mucus. The quinia, the dose of which had been lessened on the recession of the fever, was now more freely used, and he soon commenced to perspire as on the evening before, and rested well during the night. 23d, 7 A.M., respiration 36, pulse 100, skin moist. Quinine, opium, and ipecac continued as at first. 24th. He is coughing considerably, and there is a crepitant râle of great intensity in the whole upper part of the right lung very loud and dry

in front. The blistering plaster was so placed as to cover the whole of the affected side of the chest not already blistered, the posterior limit being the outer edge of the scapula. 10.30 P.M., removed the plaster and dressed with bread poultice as before. 25th, 8 A.M., a sibilant râle has taken the place of the crepitant râle, being heard all through the right side of the chest; the left side is natural. There is some oppression beneath the upper end of the sternum, a cough, which is dry and husky in the extreme, and a whispering voice. He was ordered inhalation of moist air from lime slaking in a large amount of hot water. 6 P.M., one grain of calomel was ordered in connection with the fore-mentioned powders every four hours, with a view to its constitutional effect, and incidentally to open the bowels. This last soon occurring, it was omitted for a short time, when it was resumed in a lessened dose. A teaspoonful of a syrup containing six grains of myrrh and some anodynes was made to alternate every four hours with the powders. 26th, 6 A.M., pulse 96; 9 A.M., 106; 10.30 A.M., 118; the sibilant râle is less distinct, but the voice and cough remain very husky. The bread poultice, which has been used uninterruptedly as a dressing to the chest, was now exchanged for ung. hydrargyri, at first pure, but afterwards liberally diluted with lard. During the 27th, 28th, and 29th there was general improvement except in the hoarseness. On the 30th, the patient was left in care of the attending physician. May 12th. Since taking leave of the patient I have been constantly informed of the progress of his convalescence. Extreme hoarseness continued for three weeks, and even now his voice has scarcely regained its accustomed clearness. Occasionally he coughs and expectorates. He is gaining, but is yet weak. The hoarseness seemed scarcely to indicate a laryngitis, it being supported by no other symptom. It was probably due to swelling and stiffness of the vocal cords. No remedies were used for its relief except a pectoral for the cough and a mustard-plaster about the throat.

I wish to call especial attention to the application of blisters in this disease, as therein lies, I believe, a chief source of success in the treatment. The fear that, if applied early in the attack, they may exasperate the inflammation, I have found, by often-repeated experience, to be groundless; nor has the objection of sympathizing parents to blistering the skin of tender infants any better foundation, as I have witnessed only good results even in the youngest. They should be fearlessly applied and made to cover the entire affected part, following out the line of the thorax when one or both lungs are affected. A blister that does not fulfil this requisite, or that is inefficiently managed, will fail of a beneficial issue. A piece of heavy domestic muslin, of the proper size and shape, should be sent to the druggist to be spread with cantharidal cerate, or the material be procured and a plaster prepared and applied by the physician. The cantharidal collodion may be substituted in special cases, but the cerate has proved more efficacious in my hands.

IMPETIGO CONTAGIOSA: ITS CLINICAL FEATURES.

BY HENRY W. STELWAGON, M.D.,

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IN a period of three years and a half, out of a total of twenty-seven hundred consecutive cases of skin disease, eighty-eight have been examples of the disease known as impetigo contagiosa. The cases have been, as a rule, of a uniform type, although occasional deviations in regard to the character of the lesion, distribution, and course were met with. The affection as commonly observed is well illustrated by the following case:

Case I.—R. A., male, aged 3. On face were several scattered flat vesicles and vesico-pustules and bullæ, varying in size from a pinhead to a dime, the larger ones showing a tendency to umbilication and already beginning to dry in the centre into a thin crust. The contents of the lesions were in some purely vesicular, in others vesico-pustular, all becoming vesico-pustular sooner or later. The lesions were superficial in character, surrounded by a narrow red band, and but slightly inflammatory. One of the bullæ had already dried, and appeared as a small crusted patch, the crust being thin, granular, yellowish, and wafer-like. The eruption had existed three days and had been preceded by slight malaise, and had begun as little "water-blisters," which rapidly enlarged. At the present time the child was apparently in perfect health, and there seemed to be no subjective symptoms. A brother had the same disease, as also had several children in the same neighborhood. In a few days new patches were seen on the face, one or two in the scalp, and several on the hands. The enveloping membrane of one of the new pea-sized bullæ had been rubbed off, and the surface appeared like a shallow erosion or burn, secreting a thin sero-purulent fluid. The older bullæ were drying rapidly; two or three had become confluent, making

a patch as large as a silver half-dollar, covered with the same peculiar crust as already noted. When seen two days later, the more recent vesicles had grown into bullæ, flat, umbilicated, and beginning to dry. One small vesicle had appeared on the conjunctiva of the left eye, causing slight hyperæmia and a trifling sero-purulent discharge. The confluent patch and the older bullæ were covered with a dry, yellowish and brownish-yellow, thin, granular, wafer-like crust, somewhat turned up at the edges, only slightly adherent, and appearing as if imperfectly pasted on. Several new vesicles had appeared, but showed less tendency to enlarge. One or two had been rubbed, and seemed like superficial abrasions. Forty-eight hours later all the bullæ had given place to simple crusted patches of the character already described. At the margin of the oldest patches the crust had begun to crumble off. Two days afterwards, the disease was fast disappearing; the crust of the discrete patches, with few exceptions, had entirely fallen off, leaving erythematous spots. On some of the patches a few small fragments were still clinging. At the end of a few days nothing was seen of the disease except the erythematous spots showing the site of the eruption; these gradually faded. The disease had run its course in about two weeks.

This case pictures the typical disease. At times the eruption is confined to the face, as occurred in fifteen of my cases. In others, in addition to the face the scalp shows some patches, or the disease may begin on the scalp. In others, again, the hands and arms, and not infrequently the legs and feet, are affected. The mucous membranes of the eye and nose are sometimes the seat of vesicles. Beginning usually on the face, it may extend to all parts: the trunk seems the least vulnerable. Ordinarily the eruption is seated upon the face and hands. On the extensor surface of the fingers, near or around the nail, is a favorite locality for the eruption when attacking the hands. Occurring here, it closely simulates a burn, and the lesion is, moreover, apt to be more persistent.

The disease was occasionally ushered in by fever and malaise, which subsided as soon as the eruption appeared. The submaxillary glands were in a few instances observed to be enlarged. In most of the cases, however, constitutional symptoms were entirely absent, or so slight as to escape notice. The disease is usually unattended with any subjective symptoms. Occasionally the eruption is a little itchy in the beginning; but even this is an exception. The eruption, when occurring in children with a tendency to eczema, may, if improperly treated or irritated, develop into that disease. This occurred in three of my cases, in which the primary eruption was unquestionably contagious impetigo. The lesions are superficial, and begin as vesicles, rapidly becoming vesico-pustular, enlarge by extension at the periphery into bullæ, varying in size from a split pea up to a dime or greater; at the same time the centre dries, and, in comparison with the surrounding bullous wall, seems depressed. The enveloping membrane is thin. There is no tendency to spontaneous rupture. In some cases the lesions become markedly pustular and have inflammatory borders. The eruption never leaves a scar, nor even a trace, except erythematous spots, which, however, quickly fade away. At times the lesions show very little tendency to enlarge, and then closely resemble varicella. Cracks, fissures, or abrasions are very soon the seat of the characteristic vesico-pustules and bullæ.

The disease was observed entirely among dispensary patients,—among the poorest class of dispensary patients, in fact. It can and does occur, however, among people well-to-do. In almost all of the cases the subjects were children; in only three instances was the eruption observed in adults, and in these it occurred in an abortive form, or was limited to two or three patches about the hands and face, and had been, moreover, contracted from younger members of the family. With but few exceptions, the children in whom the disease was observed were under ten years of age, and two-thirds of these under five.

The characteristic color of the crust—the straw-yellow—was often seen, but a brownish tinge, at times quite decided, was more common, depending probably upon the presence of dust and dirt.

Deviations from the typical disease were occasionally seen. The lesion itself may be somewhat anomalous in character, as the following case illustrates:

Case II.—M. A., male, aged 5. On the face were a few scattered vesico-pustules, about the size of a split pea, flat, and showing but little tendency to enlarge, and having inflammatory borders. On the arms were lesions of the same character. All were slightly umbilicated, and as the centre dried, and became thereby more and more depressed, the elevation of the surrounding bullous wall became comparatively more marked. The contents

had become milky, and later decidedly purulent, so that the lesion was not unlike a large "pock." Crusting gradually took place, yellow and brownish in color, being thicker and darker at the periphery, and with a persistent inflammatory areola. New lesions appeared from time to time, and presented the same characters. One or two typical patches were seen on the face.

Such cases, although not frequent, are not uncommon, and, when occurring, are much more inclined to be chronic and to repeated outbreaks than the typical disease. Moreover, in cases showing this character the eruption seems to have a predilection for the arms and legs, a few characteristic patches being usually seen about the face. In some instances a few such lesions were seen in cases in which the eruption in the main was typical. The eruption differs from that commonly seen in the more marked umbilication, prominence of the peripheral bullous wall, the thicker and darker crust, the inflammatory areola, the slow maturation, and, finally, in the tendency to repeated outbreaks.

At times cases are seen in which the bullæ, instead of being flat and umbilicated, are somewhat distended, and resemble very closely the eruption of pemphigus, as in the following case:

Case III.—C. R., female, aged 7. On face and forearm were several well-marked bullæ, with very little areola, and showing different degrees of distention, in some the contents tolerably clear, and in others milky. Several small vesico-pustules were scattered over the face, and a large, characteristic, crusted patch was seen on the nose. The eruption had begun as small blisters, and developed rapidly into blebs. Two children in the same family had the disease, but the eruption presented nothing unusual. Later the bullæ flattened and gradually dried, forming a thicker crust than ordinarily seen. Several new vesico-pustules and bullæ appeared, and finally the disease yielded to treatment.

Cases in which this peculiarity, the more or less distended bleb, occurs, are comparatively rare. More often one or two such lesions will be seen in patients otherwise showing the common form of the eruption. If the bleb is ruptured, the enveloping membrane sinks and becomes blended with the sero-purulent secreting base, and dries into a yellowish or brownish-yellow crust, which in time falls off, leaving an erythematous spot, which gradually fades. If the bleb-wall is rubbed off, the underlying surface appears as a simple discharging shallow ulceration or burn. When no rupture takes place, the bleb gradually sinks and dries, forming a crust somewhat thick, and resembling the crust of ecthyma, except that it is not so dark. In some instances, especially when the lesion has an inflammatory border, the resemblance at the maturing stage of the lesion to ecthyma is quite striking. This is never seen in all the lesions: one or two may exhibit this character and the rest of the eruption be characteristic. These, then, are the modifications of the lesion commonly observed and exemplified in some of my cases.

In the distribution of the eruption anomalies were noted. The first case narrated in this paper gives that usually observed,—the face, scalp, hands, and arms; it may extend to the legs and feet. In typical cases of the disease the eruption never spares the face: beginning here, it may extend to all parts, but commonly to the scalp, hands, and forearms. Deviation from this may, I think, be properly considered as irregular. The most common one met with is that in which the eruption is seated mainly on the limbs. In the cases under my care the limitation of the eruption to these parts was noted in six instances; in a number of others, although there were a few patches elsewhere, the limbs were the parts chiefly attacked. The characters of the eruption were about the same, except that the lesions were scattered, and consequently there was no tendency to the formation of confluent patches. One or two of the bullæ may be somewhat distended and dry into tolerably thick crusts. Indeed, the eruption may assume any of the characters as observed in the cases already noted.

The eruption may occasionally begin on the hands or other parts. In one case the eruption began on the knee, and subsequently the hands were affected, but no other part became involved; at the end of two weeks the disease had run its course. In another instance the eruption began on the buttocks, and subsequently appeared on the face and hands. In several cases the eruption first showed itself on the hands, and then extended to the face and other parts,—spontaneously or by auto-inoculation.

The course of the disease, as may be inferred from the histories of the cases quoted, varies. In my cases the average

was about twenty days. Other observers have noted about the same average duration. In some instances the eruption was prolonged to several months. Even if let alone, the affection is apt to be self-limited, but not always so; for in some cases, and in spite of treatment, new lesions continue to appear, and the affection persists for two or three months. It does not lose its contagious properties, however, as I have clinically and experimentally observed. Cases in which the limbs are chiefly involved seem to be most disposed to chronicity. The following case is an example:

Case IV.—R. M., male, aged 9. One characteristic crusted patch on face, several small flat vesico-pustules on the hands and arms, which later developed into small flat and slightly-umbilicated bullæ with seropurulent contents. Subsequently several appeared on the legs. Old patches crusted and disappeared. One of the flat bullæ had inflammatory borders, and the contents were markedly purulent, and dried into a thick brownish-yellow crust. New lesions continued to appear on the limbs, going through the same phases as the typical lesion. One or two appeared on the left ear, dried and crusted rapidly. In this manner the disease continued for two months, and then gradually disappeared. In this time two other children in the family were attacked, in whom, however, the disease ran a shorter and more typical course.

In their main features my cases have agreed more or less closely with those described by other writers, both in this country and abroad. All observations go to prove that, although the affection is a comparatively simple one, and the eruption usually typical, it at times presents irregular and anomalous characters.

Recapitulating, we have a contagious, auto-inoculable eruption of a vesico-pustular type, superficial in character and but slightly inflammatory, occasionally preceded by slight fever, the lesions varying in size from a pin-head to a dime or larger, always beginning as small vesicles or vesico-pustules, and enlarging by extension of the peripheral wall, with a thin enveloping membrane and a tendency to umbilication, and no inclination to rupture; drying into a thin, granular, wafer-like crust, appearing as if stuck on; seated usually on the face and hands, not infrequently on the scalp and limbs, and rarely on the trunk; tending towards spontaneous disappearance in about fifteen days; at times new lesions appearing, and the disease persisting several weeks or even months; having no influence upon the general health, and usually unaccompanied with any subjective symptoms; and observed mainly in children under ten years of age.

NOTES ON THE TREATMENT OF EPILEPSY.

BY W. THORNTON PARKER, M.D.,
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WITHOUT attempting to add anything new to the well-filled literature of epilepsy, it has occurred to me that the following cases may be of interest to the profession, if not instructive. In the first place, it is desirable to bear in mind the recognized causes of this disease. In a large proportion of cases it undoubtedly has its origin in hereditary transmission.

Bartholow,* in defining the causes of epilepsy, says, "It is a neuropathic constitution or tendency which is inherited, and this exhibits itself in various forms in different generations." In seeking for the cause of epilepsy, especially in young people, one of the first sources investigated is the character of the parents. Have the father or mother, or even the grandparents, been addicted to the use of intoxicating liquors to excess? Have either of the parents been sufferers from malarial poisoning, rheumatism, neuralgia, consumption, or insanity? The object and direction of these inquiries are easily understood: it is to discover what has seriously depressed the soundness of the nervous system or has a tendency to impoverish the general health of the body, or of both body and brain.

The cause of epilepsy is not so frequently, as supposed, to be found in hereditary transmission of the results of blows upon or injuries to the head, as it is in weakened and diseased parents, or in parents whose nervous systems have been severely injured by excesses in dissipation, or weakened by extraordinary sorrow or nervous shock. Epilepsy is more likely to be common among the poor and those who are unable to care properly for themselves or to provide for their offspring.

Imagine a family living in poorly-ventilated rooms, drinking water contaminated by exposure to foul atmosphere, subsisting

* Bartholow, Practice of Medicine, 2d edition, 1881, p. 596.

on insufficient food, existing in the midst of dirt and wretchedness, unhappy, unclean mortals, whose children grow up neglected, ill treated, frightened. In such surroundings do we find plenty of cases of epilepsy. The cause, then, seems to consist, in many cases, in malnutrition, or in severe injury or shock to the nervous systems in one or other of the parents or grandparents. It is true, however, that epilepsy can be handed down, and undoubtedly is in many cases, from parents to children; but altogether the majority of epileptic cases originate from other causes. For some years a family of several adult epileptics lived near one of our fashionable summer resorts: these people seemed to have received the disease from their parents by hereditary transmission. They lived and died town-paupers, and, so far as I know, seemed to derive no benefit from many physicians and very much medicine. They were always in need, however, of suitable food and proper care, and, in my opinion, for their own good and comfort and for the health of the community would have fared better at one of our well-regulated insane asylums.

The proportion of cases of epilepsy which can be successfully treated is so large that I consider it of great importance to understand how very hopeful the prognosis of certain forms of this disease may become if taken early in life and managed according to the plans hereinafter to be proposed. The trouble has been heretofore that almost every drug in the dispensatory has been used in vain, and that even rare drugs and minerals have been sought for and employed without much success, and the means close at hand forgotten and ignored. Epilepsy is a disease which especially demands of the practitioner an immense amount of patience and perseverance. The disease is not to be combated and defeated by intricate prescriptions or magical potions, but by persistent attention to the laws of health, to success in nutritive efforts, to overcome as far as possible morbid action in every detail. To take the sufferer from the scene of his former sufferings, and to instil in his mind hope in spite of recurring failures,—to overcome despair, which is quickly recognized by the patients, in so many of his attendants and acquaintances,—all this is undoubtedly attempted by many practitioners; but it is true, nevertheless, that many more seem to battle with this disease by the aid of drugs alone, and apparently in a hopeless manner at the outset. We have in the treatment of epilepsy much to encourage us in the hope for a successful issue. A large proportion of our patients, whether rich or poor, have been improperly cared for from infancy. They need fresh air, they need healthy homes, good food, cleanliness, cheerful society,—in fact, a decided change in the ways of living and reasoning; they will bear tonics, and in a large proportion of cases, if properly treated, will get well in a reasonable time. There are to be met with daily, on the other hand, cases neglected, too old for successful treatment, degraded, imbecile creatures,—in fact, some so hopelessly ill and so beastly in habits that death would seem to be for them and for their friends an angel of mercy. This class is not quite so numerous as formerly, and soon we shall hear of more and more success in the treatment of this loathsome disease. Many of the symptoms attributed to epilepsy are those which owe their origin to cerebral anæmia, or rather, we would say, general chronic anæmia: the whole body is diseased from lack of nourishment, the mind is distorted, depraved, and wretched in the extreme. The mind is undoubtedly affected in a large majority of cases, and this would be, considering its nervous origin and character, the condition naturally to be looked for; but, in spite of the severity of the disease upon the nervous centres, very many epileptics have possessed more than ordinarily strong minds! It is impossible, however, to associate a really healthy body or mind with a serious form of epilepsy. The health of the body and the stability of the mind must sooner or later give way under the terrible strain of this disease.

The cases to which I will invite attention were all young, from seventeen to twenty-three years of age, and of course presented the most hopeful prognosis. It is on this account highly desirable to commence treatment before the habit has become too firmly fixed and before the body is too deeply impressed and injured by this exhausting malady.

Case I.—Edward B., American, 17 years old; family history unknown, but father suspected of immoderate sexual excesses and drinking. Has sometimes two or three attacks of epilepsy in one day. Decidedly morbid appetite. Full lips, robust, bright, active boy,

well reared. Countenance pallid. Commenced treatment by clipping the hair, ordering cold bathing of head twice daily, also sponge-baths daily.

℞ Wyeth's ferri dialysatum, gtt. xii, five times daily. Milk, oat-meal, cracked wheat, Indian meal, eggs, potatoes, onions, lettuce, beef-juice, bread and butter, for diet.

To have at bedtime two teaspoonfuls of the following mixture:

℞ Brom. potass.,
Brom. sod., āā ℥ss;
Syrup. simpl., ℥ss;
Aquæ ad ℥vi. M.

This treatment had the addition occasionally of Wyeth's vinum cibe et ferri cum cinchona, half an ounce three times daily. Bread-and-milk was to be taken between meals, and before going to bed at night. No history of masturbation or other bad habits. Immediately after the attacks, and, if possible, when symptoms suggested an appearance of coming seizure, the dose of the bromides was doubled, and taken four or five times in twenty-four hours, but generally not so often. This patient soon began to improve, mentally and physically, and remained some years free from attacks, until he was at last lost sight of.

Case II.—M. C., young woman of 19. Parents Irish, supposed to be respectable; can find out no history of drunkenness in either father or mother. The children of the family are all anæmic and poorly nourished, living in a very uncomfortable and unhealthy manner. The patient has never been very strong, and is addicted to masturbation. Has had epilepsy several years, and suffers mostly about the time of the monthly sickness. Shortly before coming under treatment had four attacks in one day. Was ordered to have hair cut, to bathe the head morning and evening, allowing cold water to pour freely over the top of the head, to take sponge-baths, abstain from eating meat, and to take Wyeth's dialyzed iron, twelve drops five times daily, also the solution of bromide of potassium and sodium mentioned previously, and in the same doses, at intervals, the beef, wine, and iron with cinchona. This case improved steadily under treatment, and was free from attacks of epilepsy, with two exceptions, for three years. After that the case was lost sight of, but her whole condition had decidedly improved. Several similar cases could be mentioned; but these two are samples of the treatment used with apparently great success.

Dr. Boyé's* conclusions are that the bromides of sodium and ammonium have an immediate effect on the epileptic seizures, that they are much better borne than the potassium bromide, and that no disorder of the digestive organs occurs except the dose be very large.

The basis of the treatment of epilepsy in his institution (Sainte-Anne) consists in the administration of the bromides of sodium and ammonium, with oxide of zinc, and belladonna. The formula for the bromides is the following:

℞ Ammon. bromidi,
Sodii bromidi, aa gr. 160;
Aquæ, ℥j. M.

Cathartics seem to be very generally employed at Sainte-Anne, but in my own experience I am inclined to think their exhibition in general highly injurious. There is a preparation, however, which *is* very desirable for the treatment of the constipation so common in epilepsy,—Brewer's effervescing tartrate of soda, a very elegant, convenient, and pleasant preparation, which almost always proves satisfactory where something else than enemas is required.

"Whenever epilepsy occurs in weak and anæmic subjects, iron is indicated. Cases of this disease, essential in character and dependant on cerebral anæmia, are sometimes cured by iron alone."† After witnessing patients discolored with nitrate of silver and dosed nearly to death with every conceivable "remedy," the treatment herein suggested seems simple enough, but it will be found in many cases at least to yield the most gratifying results: at least this has been my experience, and I sincerely hope may be the experience of others also.

FORT ELLIOT, TEXAS, April, 1883.

SOME PRACTICAL POINTS IN THE USE OF MYDRIATICS.

BY EDWARD JACKSON, A.M., M.D.,
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THE following cases are worthy of note simply because they are not unusual. They illustrate the neglect of certain principles of therapeutics, well enough understood, but too often forgotten.

A. C. H., 12 years old, came under observation with headache, pain in the eyes, and dimness of vision. Her condition of refraction was hypermetropia, in the right eye 1.75, and in the left 2.75, dioptrics. Her eyes had begun to trouble her while at boarding-school, two months before. She had "belladonna dropped in them once a day for a week," according to her statement. She also said that "it made everything very misty," but she kept on with

* The Treatment of Epilepsy, Medical News, March 31, 1883.

† Bartholow, Materia Medica, 4th edit., 1882, p. 123.

her studies. In a few days she could not see to read, and, her eyes becoming more painful, she went home, and had remained out of school ever since.

I. B., aged 17, was reported to have had violent ophthalmia in early childhood. Of late, for some months, she has been suffering with aching in the the eyes and forehead. A week since, she saw her family physician about it. He said her eyes were probably at fault, and that she had best have them attended to. He then gave her medicine that would relieve her headache. While taking the medicine the pupils became fully dilated and the accommodation partially paralyzed, but the headache was no better. Her state of refraction was: right eye, H. 1.75+Ah. 0.75; left, Ah. 5, dioptrics.

Each of these patients was relieved by the instillation, for a few days, of a one-half-per-cent. solution of daturia sulphate, with the subsequent use of correcting glasses.

The beneficial influence of mydriatics in cases of eye-strain is well enough understood, and needs no further proving. It was well illustrated in the later treatment of these cases: why was it not manifested at the earlier applications?

The influence of a mydriatic over the eye to which it has been applied may be either complete or incomplete. When complete, the pupil, expanded to its widest limits, remains unchanged under all conditions of light, convergence of visual axes, etc. The iris no longer responds to the various impulses which it has been accustomed to obey: in the sense that its condition is constant and unchanged by stimuli, it is perfectly at rest. At the same time, the muscular agent of accommodation no longer responds to the circumstances and influences that usually affect it. In like sense, it also is at rest.

If the influence of the mydriatic be incomplete, very different conditions are present. The pupil is partially dilated, and the accommodation weaker than normal. But the pupil still contracts on exposure to a brighter light or when the visual axes are converged, and dilates as the axes become more nearly parallel or the light dimmer,—the influence of the mydriatic being shown merely in the fact that the pupil does not contract so much as it would normally under the same stimulus. The same is true of the muscle of accommodation. It is thrown into action by effort of the will, by convergence of the visual axes, by the constant involuntary effort to obtain clear retinal images, yet it acts less powerfully than when in the normal condition. If the eye be partially under the influence of a mydriatic, a less effect is produced by a given stimulus, or a greater stimulus is required to produce a given effect.

Now, the pathological starting-point of the class of cases to which these patients belonged is excessive exertion of the accommodative mechanism, and the first indication for their treatment is to put an end to such excessive exertion. If the influence of the mydriatic be completely powerful, this is fully accomplished. If it be incomplete, the indication is not met, for the iris and ciliary muscle, though weakened, still respond to each accustomed stimulus, and the eye-strain is increased rather than removed; and such was certainly the case with A. C. H., going on with her studies in spite of the further weakening of a previously-overtaxed muscle.

It is not necessary to consider, here, any specifically antiphlogistic influence which a mydriatic may exert over the ocular tissues with which it comes in contact. In these cases of eye-strain such influence must be of secondary importance, and powerless for good, until the cause of trouble has been removed by securing to the eye complete mydriatic rest.

The foregoing physiological and pathological facts bear upon these practical points:

First, when a mydriatic is used for the relief of eye-strain, it must be so applied as to secure completeness of its physiological action upon the eye.

Second, the periods of incomplete mydriatic influence, which necessarily precede and succeed the period of complete mydriatic rest, should be as short as possible, and during their continuance the eye should be carefully guarded from those influences that excite to action the iris and ciliary muscle.

In connection with the first point, it is to be borne in mind that full dilatation of the pupil is not that completeness of physiological action that is desired. For instance, in my own eye I can, by using a solution of a certain strength, secure full dilatation of the pupil, although one-half the normal power of accommodation remains. Again, it is in general impracticable to secure the desired completeness of action by introducing the drug through

the general system. Attempts to do this must, as in I. B.'s case, prove unsatisfactory or injurious.

In the second point is to be found the superiority of hyoscyamia, duboisia, and daturia over the more commonly used atropia.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

CLINIC OF JOHN ASHHURST, JR., M.D., PROFESSOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA.

Reported by LOUIS J. LAUTENBACH, M.D.

FRACTURE OF THE THIGH ABOVE THE MIDDLE, UNDER TREATMENT.

CASES of fractured thigh are always of interest, both during the course of treatment and at the time of the accident. To-day we have a man about 33 years of age, who has been under treatment for five weeks. The fracture was above the middle of the femur, and was, as is usually the case in adults, not a transverse but an oblique fracture. We have had him in bed constantly since the accident, and in two or three weeks more, probably, we will permit him to get up.

Of course we have here a certain amount of shortening. I believe that we never succeed in adults in curing a fracture of the thigh without shortening. In all my own cases, as well as in such cases in the hands of other surgeons as I have had an opportunity of examining, there has invariably been present shortening in a greater or less degree. In this case (by measuring from the anterior superior spinous process of the ilium to the internal malleolus in either leg) we find that there is a shortening of fully an inch. This is a fair average result. Had this man not been such a very restless patient, I am confident that the amount of shortening would have been considerably less. It is almost impossible, however, to cure a case of fracture of the thigh in an adult with less than half an inch shortening. In a child the case is different: the fracture then is usually transverse, and does not allow shortening to the same degree that an oblique fracture does. Besides this, the fracture itself may stimulate growth by irritation transmitted to the epiphyseal cartilages, and thus, after union, the bone may be for a time actually longer than the one on the opposite side. I have been in the habit of illustrating to students the union of broken bones by comparing the process to the fastening together of two pieces of sealing-wax. To do this it is necessary to melt the ends, and this is accomplished at the expense of the sealing-wax. The contiguous surfaces of bone undergo retrograde metamorphosis into granulation-tissue, and in this process there must be some slight absorption and consequent shortening. If the fracture is oblique, as it usually is in adults, there is of course probability of greater shortening, from the overlapping of the fragments.

In this case the time for extension and perfect immobility of the limb (the mode of treatment we have been pursuing in this case) has expired. We may now put on a plaster-of-Paris bandage, or some other light dressing, simply to support the parts and to prevent any risk of refracture. We will use here pasteboard splints, —binders' board dipped into hot water and given a proper shape. We will apply a bandage first from the toes up to the groin, and then, having padded the splints (which need not go below the knee) with cotton, hold them in place with another bandage outside. The fracture is firm enough for us to apply this dressing, although the patient must stay in bed for a few weeks longer. If allowed to get up at this time, the shortening of his limb might be considerably increased. In these cases, when the patient is allowed to walk prematurely, consecutive shortening occurs, the two surfaces of the fractured bone sliding on each other somewhat like the tubes in a telescope. This gives a very disappointing result, and is one to be guarded against. The patient and his friends are apt to think that as soon as he can support his weight on the injured limb he is cured and can walk with safety. This is, however, not the case: it takes a good while for the bone to become firm enough to bear the weight of the limb without giving rise to deformity.

We will apply one pasteboard splint to the inner and another to the outer aspect of the thigh, placing considerable padding under them. Over the splints we will use the ordinary roller-bandage, applied more firmly than would be justifiable if the splints were not well padded.

This dressing is not as firm as the plaster-of-Paris bandage, but has the advan-

tage of being lighter. If, however, the patient could only be seen at long intervals, the plaster dressing would be the best, as it could be left on for several weeks without renewal.

We will still keep the cradle over the limb, to prevent discomfort from the weight of the bed-clothes resting on the toes, but we will leave off the extension. We will allow the patient now to turn around in bed. There is very slight, if any, angular deformity; there is no eversion of the foot; altogether the result is a good one, although there is an inch of shortening.

TALIPES EQUINUS—OPERATION.

Our next case is one of club-foot in a boy about 14 years of age. It is not a case of varus, which is the most common form of club-foot, but it is a contraction of the tendo Achillis and of the plantar fascia, constituting the condition known as talipes equinus. It has received this name from the analogy of the horse's hoof to the toes, upon which, with the ball of the foot, the patient walks in these cases.

Sometimes in connection with the contraction of the tendo Achillis there is well-marked contraction of the plantar fascia. We have a case in the house now where the contraction was so great that it was necessary to divide this fascia in three or four places.

We will here operate on the plantar fascia first, and, after this is done, will divide the tendo Achillis. We will then apply a plaster-of-Paris bandage, keeping the foot in good position, and in a week or ten days will dispense with this and use the simple "frame-shoe," provided with steel side-supports and pads.

The best mode of treating club-foot, where the circumstances are such as to allow it, is to divide the tendons and not to attempt restoration of the foot until union has occurred, when extension is to be made very gradually. This is, I think, undoubtedly the best mode of treatment when we have the opportunity of practising it. But to apply the shoe and practise extension we cannot trust the parents or the nurse. The surgeon must apply the shoe every day himself, putting the heel well down into its place. I have found by experience that where the application of the shoe had to be intrusted to the nurse or the parents, this mode of treatment is not satisfactory. I have seen cases of varus where, although the mechanism of the shoe has been carefully explained to the parents, the child has been taken home only to return after several months or years, with no improvement in its condition. The reason is that the shoe has never been properly applied, the heel has never been brought down into its place, and in consequence the entire mechanism of the shoe has been below the foot. Of course the apparatus, under these conditions, is of no value whatever.

It is therefore better, as a rule, to divide the tendons, put the foot at once into its proper position, fix it in this position for some time, and afterwards apply the shoe.

To divide the fascia, I am in the habit of using a very small, delicate knife, even more delicate than a tenotome,—the knife recommended by Mr. Adams, of London, for his operation for the relief of Dupuytren's finger-contraction. This knife has a flat edge, the curve being only on the back. In dividing the fascia, we will cut it from above. Enter the knife flatwise between the skin and the fascia, turn the handle so that the cutting edge will present downward, and cut in the same direction. Divide all constricting bands of the fascia. Cover the opening with lint saturated in compound tincture of benzoin, and hold this in place by adhesive strips. Now divide the tendo Achillis by introducing the knife below the tendon, turning the edge upward and cutting toward the skin. Having done this, we will see if we can bring the foot beyond the right angle, which is the test to tell whether there has been sufficient division of the tendons. Cover this puncture too with a pad soaked in the compound tincture of benzoin, and take care that the strips of adhesive plaster are so applied as to make no circular constriction.

Now we want a little cotton to lay over the malleoli, and we will then apply a flannel roller, followed by a roller containing dry plaster of Paris in its meshes, which has been dipped in water. This is strengthened by the use of dry plaster rubbed over the bandage. The foot must be held in the proper position until the plaster has set,—probably from fifteen to twenty minutes.

If necessary, the patient could now go home at once, but it is better for him to remain in the hospital for a few days, as

the foot is apt to be painful when moved, from the puncture, as well as from the forcible extension which has been practised. After he has worn this bandage for ten or twelve days it will be removed, and he will be fitted with a simple frame shoe.

GUMMATOUS TUMOR OF LOWER EXTREMITY OF THE FEMUR, WITH SYPHILITIC ORCHITIS.

The next patient that we have to-day is one with an enlargement of the lower extremity of the thigh-bone. He came to the hospital with this enlargement some four weeks ago. He had a clear syphilitic history. When he came, the lower part of the thigh, as well as the knee, was enormously swollen. The swelling is now much less. There is no effusion into the knee-joint. This is easily determined by examining the patella to see whether or not it floats above or rests upon the condyles of the femur. Tapping it gently, we find that it is in contact with the condyles. It shows that the swelling is outside of the joint: it is an extra-articular swelling.

He has also an enlargement of the testicle, not the late form of syphilitic orchitis, due to the deposit of gummatous material, but the earlier form, known as interstitial syphilitic orchitis, an inflammatory condition which is often followed by great shrinking of the part. When we see a swelling of the body of the testicle, which is painless and hard, without any history of injury, we may always suspect a syphilitic origin. The tuberculous sarcocele, which is the only variety likely to be mistaken for this, does not go on long without suppuration and the formation of sinuses. There is no special treatment to be adopted in cases of syphilitic orchitis, which this undoubtedly is, except the use of the ordinary constitutional remedies. Under these alone the swelling has already diminished somewhat in size, and undoubtedly will become much smaller if the treatment is persisted in.

The treatment which we adopted for the joint-affection was the use of a posterior splint to keep the parts fixed and at rest, and the use of the ointment of belladonna and mercury, with counter-irritation by means of tincture of iodine, applied, not over the joint itself, but above and below it. Under this treatment he has been very much improved, and now I think it will be safe to apply firmer pressure and allow him to get up. We will accomplish this by means of the plaster-of-Paris bandage. We will first pad the joint well with cotton wadding, and then put on the flannel roller, fixing the joint by carrying the roller from below the middle of the leg to above the middle of the thigh. After this roller is applied we will use the plaster roller, finishing the dressing as usual by rubbing a little dry plaster outside. When the swelling goes down it will be necessary to take this bandage off and reapply it.

EPITHELIOMA OF THE CHEEK OCCUPYING THE POSITION OF A MOLE.

This old man comes here with a morbid growth of the cheek. He has a history of having had a mole for years, and within a year this has ulcerated and begun to enlarge. It is an instance of a morbid growth, at first of a non-malignant character, assuming a malignant action and epitheliomatous development. The anatomical characteristics of these cases are those of epithelioma, but if the growths are thoroughly removed the disease is not apt to return. They are favorable cases for operation. The late Mr. Collis, an eminent Irish surgeon, even went so far as to say that if epithelioma of the lip was properly removed, it would never recur. I am not prepared to go as far as this, but at least in the great majority of cases you may rest assured that, if the operation is *early* and *thorough*, the cure will be permanent. Here there is very little thickening, and the growth is quite superficial, so that there is no difficulty in its complete extirpation.

Operations in this part of the face are apt to involve some of the branches of the facial nerve. We have here made the incisions transversely, so as to run as nearly parallel as possible to the general direction of the nerve-branches. If these are wounded, in a few days the patient will notice some slight paralysis of the face, which will, however, usually disappear in the course of six or eight weeks, so that no permanent harm is done. We will bring the edges of the wound together by one or two pins, and will also use interrupted sutures. After the points of the pins are cut off and their ends protected by means of a strip, we will dress the wound with lint soaked in equal parts of glycerin and water. This is a clean application for use about the face, and the glycerin has the advantage that, by its property of absorbing moisture from the air, it keeps the dressing from becoming dry.

Our patient has other moles, situated on the face and forehead, but, as none of these have assumed a malignant character, we will let them alone.

TRANSLATIONS.

THE CHLORHYDRATE OF KAIRIN AS AN ANTIPYRETIC.—It is to Prof. Filehne, of Erlangen, that the profession owes this new antipyretic, the proper name of which, according to M. Hallopeau, is the methylhydrate of oxyquinoline. It is, like quinine, a derivative of quinoline. The chlorhydrate is a crystalline, grayish-yellow powder. In the ordinary dose of twenty-five grains (1.50 G.) it does not exert any appreciable physiological effect in a healthy person, but in fever patients it lowers the temperature, the fall being proportionately more rapid with the increase of the dose. In order that this antipyretic action may be maintained, it is necessary to continue the remedy in gramme doses (gr. xv) every two hours or so. If this is not done, the fever returns rapidly and often is attended by a chill. The urine, while this agent is employed, becomes of a dark-green color. The remedy is well tolerated, and, according to M. Hallopeau, its good effects are shown in all febrile maladies. The original introducer of the drug employed it in typhoid, acute rheumatism, septicæmia, tuberculosis, and acute pneumonia. It is claimed, indeed, that with its aid pneumonia may be made to go through its entire course without fever. Having given the agent in similar cases, M. Hallopeau endorses the recommendations of Prof. Filehne with regard to the antithermic action of kairin, and declares that "of all the antipyretic agents it is the one, in non-toxic doses, the most sure, the most powerful, and the most rapid." It will enable us to avoid the dangers which hyper-pyrexia brings in its train, and is therefore a valuable medicament, "une ressource précieuse pour la thérapeutique" (*Revue de Thérapeutique Médico-Chirurgicale*, No. 10, 1883.) From a series of trials made by Drasche in pneumonia, erysipelas of the face, phthisis, and a bad case of typhus, reported to the Royal Society of Physicians in Vienna, substantially the same conclusions were reached, and kairin was pronounced the most prompt and efficient of all antipyretics.—*Centralblatt für Chirurgie*, No. 28.

[Unfortunately, its high cost, at present, will be likely to limit its usefulness.—ED.]

TREPHINING FOR TRAUMATIC RUPTURE OF THE MIDDLE MENINGEAL ARTERY.—At the meeting of the Zurich Medical Society (*Korrespondenzblatt für Schweizer Aerzte*, 1883, No. 1), Dr. Kronlein reported two interesting cases: A man 48 years of age fell and struck his head against a step. After half an hour he regained consciousness and walked into his house. He seemed perfectly conscious until midnight, when he went to sleep; but in the morning he was found again unconscious: he was then taken to the hospital. When admitted, he was in a state of sopor, without paralysis. The next day there was paresis of the right leg, complete paralysis of the right arm and face, with ptosis. As the symptoms pointed to meningeal hemorrhage, the reporter trephined the skull over the trunk of the middle meningeal artery, but he found it intact and did not find any extravasation. At the autopsy a large effusion was discovered, however, which had depressed the underlying brain-substance, and which came from a posterior branch of the same vessel. The second case was a man 60 years of age, who was brought into the clinic unconscious and hemiplegic. He was in a deep sopor, and the left side was powerless. As his condition at the end of a week had become worse, the operation of trephining was performed at the location indicated by Vogt over the middle meningeal artery. A large extravasation was at once encountered and removed, separating the dura mater from the skull for about an inch and a half. The clot removed was about 140 to 150 Gm. The wound had entirely healed at the end of four weeks, and the patient recovered with only a slight facial paralysis.—*Centralblatt für Chirurgie*, No. 28.

MUSCARIN-POISONING SIMULATING CHOLERA.—In a brief communication Prof. Boehm, of Marburg, calls attention to exfoliation of the epithelium of the bowel as the result of poisoning, which, with the attendant diarrhœa, might be mistaken for an attack of cholera. He states that there are two forms of poisoning in which the epithelium is cast off from a large part of the intestinal mucous membrane and is dis-

charged with the dejecta,—acute arsenical poisoning, and intoxication with several members of the mushroom family. The former has been already brought to the notice of the profession; the latter is of recent discovery by him, and has not been previously published.

The animals experimented upon were cats. Muscarin being administered by subcutaneous injection, "choleriform symptoms appeared: violent vomiting and purging, which at first was fæcal; afterwards white masses of mucus were discharged by the anus, containing partly isolated epithelial cells, and partly membraniform casts shaped like a glove-finger." These appearances are worthy of note in a community in which mushrooms enter into the daily food, and in which a cholera epidemic is threatened.—*Virchow's Archiv*, June, 1883.

PHYSIOLOGICAL ACTION OF ADONIS VERNALIS.—From a careful physiological and clinical study of the effects of Adonis vernalis, Dr. Bubnoff arrives at these conclusions:

1. The active principle of Adonis vernalis excites the inhibitory nerves of the heart at the central end.

2. Its further action is to paralyze the peripheric end of the vagus.

3. It likewise excites the accelerating system of the heart, sometimes directly (through the blood-pressure), sometimes indirectly.

4. Up to the moment at which paralysis of the vagus occurs, the two systems of cardiac innervation interfere.

5. At the termination of the toxic effect, paralysis of the motor nervous apparatus of the heart apparently occurs.

6. After death there is either complete loss of excitability of the cardiac muscle or it is very much weakened.

In man, this agent caused more gastro-intestinal disorder (vomiting and diarrhœa) than digitalis ordinarily does, and in certain individuals the effect upon the central termination of the vagus was more marked than from digitalis; and in one series of cases with disordered compensation of the blood-circulation, after digitalis had failed, the Adonis was given with decidedly good results.—*Deutsches Archiv für Klin. Med.*, June, 1883.

DIRECT COMMUNICATION IN THE LIVER BETWEEN THE BRANCHES OF THE PORTAL AND HEPATIC VEINS.—Sabourin finds in the substance of the liver, along the course of the larger divisions of the portal vein, some branches of the hepatic vein which lie in the periportal connective tissue, and, although direct communication between the portal and hepatic veins has not been actually demonstrated by microscopical sections, he is convinced that such actually exists, an opinion to which he was first led by his pathological studies. Claude Bernard also held this view, upon the physiological postulate that the capillaries are not competent to conduct the large amount of fluid carried to the liver during digestion, the greater proportion of which then would flow directly through these large communicating branches from the portal vein into the hepatic. In the intervals of digestion the blood is prevented from passing through these vessels by a sphincter-like arrangement of muscular fibres and connective tissue, the exact character of which further experiments will be needed to determine.—*Progrès Médical*, No. 8.

DIABETES AS A SYMPTOM OF INTRACRANIAL DISEASE.—A child four and a half years old, previously healthy, had for nine months experienced constant thirst and increased excretion of urine without nervous phenomena, but the patient lost flesh and became gradually weaker. At this time the symptoms of tubercular meningitis developed, and she died after a fortnight's stay in the hospital. The quantity of urine was very great: on one day it was nearly ten litres.

At the autopsy, besides a tubercular meningitis, there was particularly observed a caseous tubercle of the infundibulum and a spot of softening in the corpus striatum, with distention of the lateral and fourth ventricles.

CURIOUS MALFORMATION OF THE HEART.—In the *Progrès Médical* (No. 23) is described and figured a case of congenital malformation of the heart by Dr. Gilbert, of Havre, in which there was a prolongation, like the finger of a glove, of the left ventricle, through a deficiency of the anterior portion of the diaphragm, into the abdominal cavity, and so as actually to form a part of an umbilical hernia. The child died of pneumonia at ten months. The specimens were presented at a meeting of the Société de Biologie.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, SEPTEMBER 22, 1883.

EDITORIAL.

MEDICAL EDUCATION.

EVER since the *Philadelphia Medical Times* has been under its present editorial management it has systematically and with all boldness exposed the iniquities of the American system of medical education, and has pointed out the sole thorough remedy,—namely, the taking from the colleges the right to grant licenses to practise. So long as men can make thousands of dollars yearly by the sale of diplomas and hide their crime under the cloak of teaching, so long will the consciences of many be numb and without feeling. In spite of all that has been said, it is still considered respectable to hold these positions, and men yet come from distant places to take them. There are, it is true, symptoms that the day is approaching when honorable men will be found to decline connection even with money-making doctor-factories, but the approach is with woful slowness.

Public opinion has already done something, and may do more, in controlling medical education; but the evil can only be rooted out by separating teaching and licensing,—by requiring every new M.D. who desires to enter practice to pass an examination before an official licensing board which should not only have no direct connection with teaching, but also have no teacher among its members.

The world moves. We have seen the cause of proper medical education gain enormous headway during the last few years, but we had no idea that the millennium was approaching so rapidly as it seems to be from a recent editorial in the *New York Medical Record*, where it is affirmed that there can be but little doubt that the Legislature of the State of New York will before long give serious consideration to the matter of creating a State Examining Board as a sole licensing body. We agree with the *Record* that the success of any law will depend upon its details. The chief difficulties to be met are in regard to the appointment of examiners, and the relations of the homœopathic practitioners. The appointments must be kept out of politics. This can readily be achieved by giving the appointing power to the State Medical Society. Whether we like it or not, it is sure that if success is to be achieved the existence of homœopathy must be recognized in the formation of the Board. Possibly two Examining Boards, one appointed by the Homœopathic State Association and one by the State Medical Society, might be allowed; possibly the subject of therapeutics might be dropped out entirely; possibly it would be best to have a Board homogeneous and uniform in all respects save only in regard to therapeutics, which subject should be represented by two or three individuals.

The time will come when the earnest discussion of these details will be a pressing duty; but at present all that we can do in this State is to hurry along the tide of public opinion, which is now drifting towards the measures that have been adopted in all civilized portions of the world save the United States.

THE CONCLUDING VOLUME OF AGNEW'S SURGERY.—We have already noticed in detail in the review pages of our journal the appearance of the first two volumes of this gigantic work. It is now with great pleasure that we congratulate Prof. Agnew on the completion of the whole,—a life-work, which is a great contribution to the written experience of those who toil that human suffering may grow less and less.

TROUBLE.

JUST now the homœopathic fraternity are to a more or less wide extent sorely exercised by the discovery of one of their number, Dr. J. Edwards Smith, that the sugar of milk, universally employed as an inert vehicle in the making of triturations, is as universally impure. In the language of the homœopathic leader,—

"The first effect upon the mind which an unquestionable proof that *all sugar of milk*, wherever bought, contains at least enough silica, alumina, and iron to constitute itself the sixth decimal potency of these drugs, if it have received the requisite amount of trituration, is a fact which seems stupendous when we reflect that many of the polycrests may only be prepared by trituration, while the process has been adapted to many other drugs. The matter is not benefited apparently by the fact placed on record by Dr. Conrad Wesselhoeft, that the glass of bottles, such as we use for preserving dilutions, is to a very appreciable extent soluble both in water and in 95 per cent. alcohol. We see at once that whenever we have prescribed an attenuation of any remedy we have in reality administered two or more drugs; and, furthermore, with reference to silica, alumina, and iron, we have never given either of them in a potency higher than the sixth decimal, if we measure potency by dilution rather than by dynamization."

Verily, with the discoveries of modern science becoming more and more brilliant, the way of the honest, sincere homœopath is growing hard; but then the race of honest, sincere homœopaths who toil along this pathway, rugged and stony with its absurdities and its contradictions, is almost extinct. It is the by-path of pretence and fraud whose rough places are being trodden smooth by so many feet eager to barter self-respect for gold.

LEADING ARTICLES.

HOANG-NAN.

THERE is at Tonkin a plant of the genus Strychnos, the bark of which possesses very astonishing therapeutic virtues, if all that is said about it be true. This plant, or rather climber, is called in the Annamite language hoàng-nàn. We are indebted to Mr. Romanet du Chailland, of the Geographical Society of Paris, for our knowledge of the very curious therapeutic properties of this plant.

It is said that the knowledge of the medical virtues of the hoàng-nàn was formerly the secret of an indigenous family. The family having abjured their religion for Christianity, its chief did not hesitate to reveal this secret to the missionary who had instructed them in the Christian religion. It was thus that the abbot Lesserteur, to-day governor of the foreign missions in Paris, formerly missionary himself at Tonkin, acquired a knowledge of the existence of that Strychnos and of its virtues, concerning which he wrote a work to which Mr. Romanet du Chailland refers.

The hoàng-nàn, according to these authors, cures hydrophobia. Mr. Lesserteur mentions two cases of declared madness which have been cured at Tonkin by the application of that remedy. One of these cases has been certified to him by a missionary named Perrier, established in the country for about twenty years. This missionary cured a young girl of fourteen years old, of the village of Xuan-Yen, at the height of the disease. Mr. Perrier gave to her three large pills (more than a drachm), and some moments after two others containing about forty-five grains. The patient fell as thunderstruck, then entered into lethargy, and was soon cured.

When the madness is fully declared, as in the case above, it is necessary, according to the abbot Lesserteur, to act with energy. The patient swallows, with the aid of a tablespoonful of vinegar, at first two or three pills, after these several others at short intervals, until twitchings of the feet and hands and contraction of the jaw-muscles are felt.

On account of giving water as a vehicle of the remedy, the experiment performed, it is said, with the hoàng-nàn in one of the hospitals of Paris had no favorable result. The operator wished then to employ hypodermical injections, but the quantity brought to him was not sufficient, and while a stronger dose was looked for the patient died. Mr. Romanet du Chailland declares that the remedy is now being studied at the school of Alfort, and that the savant, Mr. Pasteur, had promised to experiment with it.

In Algeria three missionaries of the congregation of Africa, bitten by a mad dog, have been cured by this substance. But this is not the only property of the hoàng-nàn. They say that this strychnia is an excellent antidote to snake-poison. Studies on this subject would be of a great interest.

Finally, the hoàng-nàn is asserted to have been used with success at Pondicherry, in the West Indies, and in Venezuela, to combat leprosy. It is also said that it is powerful for scrofulous and venereal diseases.

F. EMERY.

August 27, 1883.

NOTES FROM SPECIAL CORRESPONDENTS.

CHICAGO.

THE summer just now passing away has been the most remarkable for many years. Certainly nothing like such a continuously low temperature during June, July, and August has been experienced for more than a decade, and yet the health of the city has been as exceptionally good.

We are having a needed addition to our hospital accommodations in the new hospital building now in process of construction upon the block adjoining Rush Medical College. The building is to be about seventy-six by one hundred and forty-seven feet, four stories and a basement, of brick, with stone trimmings. When completed, this hospital is to be under the college board, and will be directed in the interests of Rush, thus giving the school a special advantage over all competitors in this part of the country.

Professional and social circles are just now agitated over a scandal involving the good name of one of the leading, and until within a few weeks most highly respected, physicians in this community. Dr. H. W. J. resided in the west division, had a palatial residence, a very extensive obstetric practice, a princely income, and an enviable social position. The doctor is past fifty, good-looking, is finely educated, and has an exceptionally pleasing address. His wife is a lady possessing like accomplishments. About two years ago Dr. J. gave some passing professional attention to a very handsome society woman, by whom he became fascinated. It now appears the woman was a sort of adventuress, and the doctor, being ignorant as to the ways of her kind, yielded to the unhealthy influence, was fascinated and powerless under the charm of her beauty and many accomplishments, and in less than two years he surrendered everything, loving wife, good name, fortune, and with the wife of another man has gone away forever. The profession of the city is deeply stirred, because Dr. J. is the last man to have been suspected of any such action.

The investigation into the lard frauds came to a farcical conclusion: the scientific experts gave the most conflicting testimony, even contradicting themselves. Dr. R. stated that samples "A" and "B" were composed of lard and tallow, whereas they were pure lard. Professors Curtis, Long, and Walter Lee Brown were in like manner embarrassed. The fees paid experts varied from five hundred to three thousand dollars each.

It is rumored that Dr. Roller is about to retire from the chair of Obstetrics in Chicago Medical College, his health having become much impaired.

September 10, 1883.

PROCEEDINGS OF SOCIETIES.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, THURSDAY, September 6, 1883.

The PRESIDENT, R. A. CLEEMANN, M.D., in the chair.

DR. WM. T. TAYLOR read the report of a case of

FACE-PRESENTATION WITH ECLAMPSIA.

Face-presentations are somewhat rare. Dr. Churchill, some years ago, in recording the statistics, found that in British practice they occurred once in two hundred and ninety-two cases, in French practice once in two hundred and seventy-five, and in German practice once in one hundred and thirty cases. In my own practice I have met with about one dozen; and, as the last one was combined with eclampsia, I will report it to the Society.

During utero-gestation my patient enjoyed very good health, having no headache, no swollen limbs or bloated features, no vertigo or dimness of vision. There was no deficiency of urine, and therefore I did not examine it for albumen. Her appetite was fair, her bowels regular, and she took a moderate degree of exercise: so that I had no reason to expect any trouble when labor began.

On May 14, 1883, I was summoned at 6 A.M. to visit Mrs. C. H., aged 23 years, primipara, who was in the first stage of labor, having had a show since midnight. On examination, I found the os very slightly dilated, with the pains "few and far between," and the face of the child presenting, with the chin towards the sacrum. The nurse informed me that the patient had not slept during the night and was very nervous and irritable. Her skin was moist, her pulse normal, and she had urinated frequently.

I gave her a mixture containing hydrate of chloral, bromide of potassium, and valerianate of ammonia, to compose her, and went home for my breakfast, intending to return in a few hours.

At eight o'clock the husband came to my office and told me that his wife had "had a fit and could not keep the medicine down." I arrived at the house at 8.30 A.M., and sent

immediately for some powdered hydrate of chloral and an injection-apparatus. The patient had had two convulsions, which were ushered in by complainings of her head, her face being very red and her head drawn to one side, with the features much distorted. The first convulsion occurred when the nurse was about to give the first dose of the medicine. Directly after my arrival a third convulsion occurred, and lasted for a minute or more, her head being violently drawn to the right side, with jerking of her arms and legs.

I dissolved one drachm of the hydrate of chloral in about four ounces of water, and threw it into the rectum. The fit yielded immediately. As she was unconscious, I had an excellent opportunity of examining her. The os was dilated to the size of a quarter-dollar, and soft, so that it yielded gradually to the pressure of my fingers, when I discovered the face-presentation, with the chin towards the left sacro-iliac junction. I endeavored to push the chin towards the breast, so as to bring down the occiput in the second position of Baudelocque. This I found somewhat difficult, but as the os dilated under the pressure of my fingers I reached the occiput, and after several attempts succeeded in bringing it down to a favorable position, the one aforesaid. My patient by this time was becoming restless and uncontrollable, and, fearing another convulsion, I again gave her an injection of chloral, which quieted her. Having placed her on her back and brought her to the edge of the bed, her limbs being supported by the nurse and a neighbor woman, the forceps were easily applied, and the head brought down below the inferior strait. I removed the instruments, when the head pressed against the perineum, allowing nature to finish the delivery. The child, a boy, was still, the cord being pulseless. In fact, I was apprised of this whilst endeavoring to dilate the os with my fingers, for a significant tremor had passed through the body of the child, assuring me of its death. The placenta was removed quite easily.

During all this time my patient was unconscious, and had no return of convulsion from the time I gave her the first injection of chloral.

As her pulse was good and her respiration easy, I applied a binder, and, having placed her in a comfortable position, left her sleeping. On my return at five P.M. she was restless and slightly feverish, but after taking a few doses of chloral and valerian she was quieted to sleep. On the next morning, May 15, she was perfectly conscious,—pulse 80, temperature 99°, and respiration normal. She had urinated freely, and, with the exception of some slight soreness over the abdomen, was very comfortable. She inquired for the babe, knowing from her condition that it had been born, but the preceding twenty-four hours were to her a perfect blank. From this time she had no further trouble, and soon recovered. This case certainly showed the beneficial effect of injections of hydrate of chloral in controlling puerperal convulsions where they are of a nervous form.

Dr. ALBERT H. SMITH remarked that face-presentations and puerperal convulsions presented a large field for discussion. Dr. Taylor was very fortunate to be able to bring down the occiput and keep it so until the forceps could be applied. In this operation a man needs three hands,—one to hold the head while the others manipulate the instrument. The mechanism of a primary face-presentation, as reported in this case, is difficult to understand. It may occur secondarily from obliquity of the uterus and a sudden, free gush of waters, causing a rapid engagement of the head before flexion could be secured. In such cases it is very difficult to secure and maintain flexion until the forceps can be applied. In the majority of cases of face-presentation, even with the chin posterior, nature is best able to terminate the case satisfactorily. It is to this class that the aphorism "meddlesome midwifery is bad" is most applicable. The natural forces work slowly, and the neck of the child becomes accustomed to the extreme extension which it has to undergo; while it is very bad to bring, by means of the forceps or otherwise, a sudden strain on the vertebræ and other tissues of the neck by too rapid forcing of the chin into violent extension. The consequence of the hasty proceeding is a still-born child. The only ground for interference is an alarming condition of the child's pulse. If the child's heart is beginning to fail, we must take the risk and give it the benefit of the chance. The child's head cannot be born in face-presentation until the chin has engaged under the pubis. The old teaching was that the chin posterior could not be born, but he was very early undeceived on this point, one of his earliest cases having been of this character. He had sent for his preceptor to come and bring perforating instruments, but while awaiting their arrival nature proved equal to the task, rotation occurred spontaneously, and a living child was born.

Dr. B. F. BAER inquired if version by the feet would not be much preferable to waiting for nature to deliver in chin-posterior positions.

Dr. SMITH did not mean that we should never interfere in a case of this kind, but that a large majority, if left to nature, would terminate spontaneously by anterior rotation of the chin, with safety to both mother and child. He would decidedly negative the proposition of version by the feet, because, the amniotic sac having been necessarily ruptured by previous efforts to bring down the vertex, the waters would have been completely evacuated, the uterus would be in a condition of spasmodic contraction, and an at-

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tempt to turn would involve great danger of rupture of the uterus. The introduction of the hand always increases the risk of septic absorption, two terrible risks against the mother, while the child is exposed to all the dangers of head-last delivery. He should consider chin-posterior presentations natural labors, and should allow them to terminate spontaneously unless there was some complication demanding version.

Dr. J. G. ALLEN coincided with Dr. Smith in his conservative principles. The risks of version to the mother are great,—too great to allow it to be performed for the sake of the child. The operation of version is not looked upon in as serious a light as it should be under all circumstances. In some instances it may be very easy and may terminate well, but in others, apparently similar in conditions, the results to the mothers are bad. He would not lose one mother to save ten children. He would never resort to version unless the labor were impossible under other measures. Even after it is skilfully performed, the child is often still. The increased risk to the mother is followed by no corresponding gain in safety to the child.

Dr. R. P. HARRIS thinks the ideas of Dr. Smith are the same as held by most eminent obstetricians, and agrees with their practice as expressed to him in private correspondence.

Dr. BAER was willing to be taught. The views expressed this evening did not harmonize with the teaching of even the present day in Philadelphia. He had been taught that version would be proper if the case was diagnosticated early and the operation could be performed before the waters were evacuated, and it seemed to him that the rational thing under such circumstances would be to turn. It was entirely a new light to him to consider chin-posterior cases as easy natural labors. He had been taught to look upon them as impossible, and that rotation never took place, the forces in action not being great enough to compel it. His own recent experience had led him to doubt this dictum: with one blade of the forceps used as a vectis, he had without difficulty secured anterior rotation. His idea of the impossibility of rotation under the circumstances made him doubt the correctness of his diagnosis of the position, but the principles put forth this evening reassured him. May the death of the child, causing relaxation, be the cause of the face-presentation?

Dr. ALLEN does not expect others to accept his opinion, but in his denunciation of turning he alludes to the complete transposition of one extremity of the fœtal ellipse for the other, and does not include the changing of one part of the head for another; but in the first class the poor chance of saving the child will not compensate for the increased danger to the mother.

Dr. SMITH does not consider chin-posterior an easy natural labor. On the contrary, it is the most difficult of natural labors. The chin strikes upon the posterior inclined planes and is rotated to an anterior position, in which it engages under the arch of the pubis exactly as the vertex would. In multiparæ nature is able to accomplish this result, but in primiparæ assistance in rotation may be required and even traction may become necessary. In contrasting the dangers incident to version by the feet and those involved in trusting to nature in this condition, when the waters have been discharged, as they necessarily have, in the attempts to bring down the vertex, which will be first tried, we must remember that the child will be tightly grasped by the uterus, and that it must be twisted upon its long axis as well as turned to bring the nape of the neck under the arch of the pubis, and that this procedure will greatly enhance the danger to both mother and child.

Dr. TAYLOR, in closing the discussion, remarked that the death of the child occurred after it was fully engaged, and was not a factor in causing the face-presentation. When he made his diagnosis of position the head was high up, and, the child being small, he had no difficulty in bringing down the vertex.

W. H. H. GITHENS, M.D.,
Secretary.

REVIEWS AND BOOK NOTICES.

ON THE MORBID CONDITIONS OF THE URINE DEPENDENT UPON DERANGEMENTS OF DIGESTION. By CHARLES HENRY RALFE, M.A., M.D., Fellow of the Royal College of Physicians, London, etc. 12mo, pp. 148. London, J. & A. Churchill, 1882.

This little book has long been upon our table, but its notice has not been deferred because of any distrust of its merits, in which it is far richer than many more pretentious works. Its title of "Morbid Urines" is scarcely correct, for we would rather term it Derangements of Digestion and Nutrition in which Morbid Conditions of the Urine are a Symptom. They include acid dyspepsia, flatulent dyspepsia, derangements associated with deposits of uric acid, with oxalic acid, and with excessive elimination of phosphoric acid. The book opens with a chapter on the formation and removal of acid from the body, and an appendix on the effect of bicarbonate of potash on the acidity of the urine.

The questions arising are discussed from a chemical stand-point, and the therapeutics suggested, full of practical value, are largely based on sound chemical reasoning. It would seem as though the mantle of Bence Jones is likely to fall upon Dr. Ralfe, and that it will be worn as gracefully by him as by his illus-

trious predecessor. Indeed, it is not unlikely that the more accurate chemical pathology and therapeutics will rest upon a sounder basis and lead to more satisfactory practical results than heretofore.

We commend Dr. Ralfe's little book to the close study of the profession, and are confident that all who read it will feel that it has been profitable to do so in more ways than one. J. T.

A Practical Treatise on the Medical and Surgical Uses of Electricity. By George M. Beard, M.D., and A. D. Rockwell, M.D. Fourth Edition. Revised by A. D. Rockwell, M.D. William Wood & Co., New York, 1883.

The death of Dr. George M. Beard has thrown the revision of this work into the hands of his colleague, who has in all respects maintained the peculiarities and the reputation of the work. The most important addition to the present edition is the chapter on the electrical treatment of extra-uterine pregnancy; the subject of franklinic electricity is also considered in detail. Dr. Rockwell certainly brings forward enough evidence to necessitate the making of an attempt to destroy the fœtus by galvanism in every case of extra-uterine pregnancy in which the positive diagnosis is made out sufficiently early.

Types of Insanity. An Illustrated Guide in the Physical Diagnosis of Mental Diseases. By Allan McLane Hamilton, M.D. New York, William Wood & Co., 1883.

This quarto consists of ten plates, with their explanation, and about thirty-six pages of text. The plates are apparently lithographs, which are said to have been taken from instantaneous photographs. Some of them are recognizable as portraying forms of mental disorders; others of them have to our eyes no significance. None of them compare in any way—except as bad art compares with good—with the famous engraving by Kaulbach of a mad-house yard.

Most of the text bears very little relation to the illustrations. It is arranged in five chapters, as follows: I. General appearance, physiognomy, posture, etc., of the insane; II. Conditions of special organs; III. Conditions of bodily functions; IV. Examinations of patients, of handwriting, etc.; V. The commitment of the insane, and abstracts of the laws in the various States. To us the last chapter is the most valuable of the book; although the physician who has had little experience may pick up here and there in other portions of the text observations and suggestions to him novel and interesting.

Hand-Book of Electro-Therapeutics. By Dr. Wm. Erb. Translated by L. Puzel, M.D. New York, Wm. Wood & Co., 1883. 8vo, pp. 366. The June issue of Wood's Medical Library. A handsomely-printed edition of a standard work, with thirty-nine wood-cuts.

GLEANINGS FROM EXCHANGES.

A Case of Progressive Total Hemiatrophia.—Dr. Henschen, of Upsala, relates in a recent number of the *Nordiskt Medicinskt Arkiv* a case which is almost unique in medical literature,—presenting, as it does, a series of atrophic changes of half of the body, in the skin and subcutaneous tissue, as well as in the muscles, bones, and joints, principally in the face, the left arm, the left leg, and partly the left half of the trunk. The patient is still living, and therefore the pathological changes cannot be defined with any accuracy; but the appearances of the body, which are represented in a plate accompanying the paper, are very striking, showing an extreme degree of emaciation of the left arm and leg, and an appearance of the face almost identical with that seen in progressive facial hemiatrophia. The cranium above the eyebrows is nearly symmetrical, but on the plane below them the face exhibits a most marked asymmetry, the left half being considerably smaller than the right. The nose is, as it were, pushed towards the left; the left cheek is deeply sunken, destitute of fat, and surrounded with deep radiating wrinkles; the eye is very much sunken, but otherwise healthy; the eyelids deprived of their fat; the left zygomatic arch atrophied, as well as the soft parts surrounding this bony process. The skin and the lips of the left side are very thin; the upper and lower maxillary bones of this side are much atrophied. The teeth have been shed; the alveolar process of the left upper maxillary bone is wanting behind the second molar tooth, and the raphé of the palate is drawn to the left. All the right side of the face is healthy, with abundant fat. The neck is symmetrical. All the left half of the trunk is rather smaller than the right, but, with this exception, it is nearly alike, though some of the parts are atrophied. Over these atrophied parts the skin is as thin as paper, and the subcutaneous fat is almost entirely wanting, so that the muscular fibres form evident projections on the skin. The left arm and leg are remarkably atrophied, the fat being almost completely absent, the skin very thin, the muscles wasted, the joints altered in character, and some of the bones united together,—as, for instance, the tibia and fibula,—and the tibio-tarsal joint is anchylosed. The tactile sensibility of the atrophied parts is not remarkably altered, except that the left leg is more sensitive than the right, being more easily affected by cold, and perhaps also by electric irritation. The patient, who is now forty-six years old, was healthy up to the age of fourteen, when he suffered from a slight sprain of the left ankle-joint, and shortly afterwards he had an erysipelatous inflammation of the left leg. Since that time he suffered from pricking and shooting in the

left half of the body, and at the end of three months some changes appeared in the extremities and the trunk, and, six months later, in the face. At this time he suffered from severe attacks of headache. At nineteen years of age he had melancholia, but he recovered, and now enjoys good health. He married at the age of forty, and had a healthy and well-formed child. All the changes above described first appeared, therefore, a short time after a sprain of the left ankle-joint. They have continued since that period, and the morbid process went on ascending to the central nervous system, the anatomico-pathological process being at present unknown, as well as the course which it has followed in the nervous centres.—*Medical Times and Gazette.*

MOLLUSCUM CONTAGIOSUM GIGANTEUM.—Under this name Dr. S. Laache, of the Anatomico-Pathological Institute of Christiania, describes, in a recent number of the *Nordiskt Mediciniskt Arkiv*, a tumor extirpated from the nape of the neck of a female, aged 56. This tumor, which had lasted for thirty years, but had increased considerably for the last four years, was of the size of the fist, with nodulations or unequal protuberances on the surface; it was covered at its base with normal skin, sending tongue-like ramifications over the whole tumor, and which were transformed at last into a delicate membrane, half pellicular and half granular, covering the whole mass except at the summit, where there was a flat crateriform depression. Under this incomplete covering there was the mass of the tumor, which, as it were, undulated against the surface. The cut surface, equally composed of nuclei of unequal size, separated by septa of cellular tissue, presented a granular aspect, but without the knife being covered with adipose matters. Examined by the microscope, the lobules contained, in the circumference, cellules evidently resembling epidermis, while in the centre were seen a considerable quantity of corpuscles with an adipose or waxy lustre strongly resembling amyloid tissue. In all other respects they resembled the corpuscles of molluscum, with which the author compared them. In his remarks on the case, Dr. Laache discusses the differential diagnosis between molluscum and epithelioma or cancroid, to which last the tumor was at first referred. From cancroid, however, the molluscum in question was distinguished by its definite form and its tendency to grow outwards, besides by its being covered entirely by a kind of delicate skin without any apparent ulceration. It was, however, the presence in considerable quantity of corpuscles of molluscum which determined the diagnosis. The author admits, however, that, as regards prognosis, the tumor could not be regarded as being so benignant as ordinary molluscum, and he therefore thinks he ought to consider it as a transitional form between the malignant epithelial tumor and the benignant one. He observes that there was no relapse at the end of more than six months. In conclusion, Dr. Laache considers the presence of nuclei in several of the shining corpuscles as a proof in favor of the opinion that the corpuscles of molluscum are the results of a peculiar degeneration of pre-existent epidermic cellules. —*Medical Times and Gazette.*

VERSION.—Dr. Grosholz reported to the British Medical Association a series of fifty cases of version without a maternal death. The infant mortality from all causes was 1 in 2½, but taking only those fairly attributable to the operation it was only 1 in 3½. Regarding the causes necessitating operation, he stated that as turning is generally understood to mean a restoration of a child to its normal position in the uterus, or the substitution of some other portion of the body for that originally presenting, it will not seem surprising that the operation was performed for the rectification of some malposition of the fœtus in thirty-eight out of the fifty cases. Of the remaining twelve, five were cases of placenta prævia, four of contraction of the pelvis, and three of uterine inertia. We thus see that thirty-eight, or about four-fifths, of the cases in which the operation was performed were cases of *malpresentation* of the fœtus, four of *malformation* of the mother, five of *malposition* of the placenta, and three of failure of the uterine contractions. To go a little more into detail, he has tabulated the above facts as follows:

Malpresentation .	Shoulder . .	18	38
	Arm and funis	8	
	Arm	6	
	Face and hand	3	
	Brow . . .	1	
	Brow and hand	1	
	Back . . .	1	
Pelvic contraction			4
Placenta prævia			5
Uterine inertia			3
			50

In performing the operation he prefers the bimanual method, by combined internal and external manipulation, to introducing the whole hand into the uterus. He recommends turning with the left hand, the patient lying upon her left side. He found it decidedly advantageous to bring down only one foot or knee, instead of both, and advised the use of chloroform for its relaxing effect upon the uterus, thus in a measure preventing lacerations. The operation should be performed, if possible, before the membranes are ruptured: in a case of placenta prævia he introduced his hand to one side in preference to penetrating its substance.—*Lancet*, August 11, 1883.

PROFESSOR ERB ON THE ETIOLOGY OF TABES DORSALIS.—In 1881, Professor Erb published his first series of 100 cases of tabes dorsalis, showing the frequency of previous syphilis in this disease. In 88 of these cases there had been previous syphilis, in 12 there had been none. Since that date, Fournier, in his work on "Locomotor Ataxia of Syphilitic Origin" (1882), gives the percentage of cases in which there had been previous syphilis as 93; Vogt, a former opponent of syphilitic tabes, in his latest statistics, gives the percentage as 81.4. The *Berliner Klinische Wochenschrift*, No. 32 of this year, contains a paper by Erb giving a second series of 100 cases of tabes dorsalis. Out of this series, 9 only of the cases had had no syphilis, while 91 had had previous syphilis. Of these 91 cases, 62 had undoubted secondary syphilis, 29 had primary sores, but no secondary symptoms were noticed. Of these 29 cases, 5 had true hard sores, 10 were treated with mercury and iodide of potassium, and in 14 the treatment and the nature of the sore are not noted. The tabes dorsalis manifested itself at the following periods after infection with syphilis: 13 cases occurred between the first and fifth years, 31 between the sixth and tenth, 25 between the eleventh and fifteenth, 15 between the sixteenth and twentieth, 5 between the twenty-first and twenty-fifth, 1 between the twenty-sixth and thirtieth, and in 1 case the period was unknown. Thus, 69 of the 91 cases occurred during the first fifteen years after infection, 15 in the period between fifteen and twenty years, and 6 still later. As a check observation Professor Erb ascertained that of 1500 patients who attended his clinic, who were not tabetic, 77.25 per cent. had never had syphilis, and that 22.75 per cent. had been infected. Of these latter, 10.25 had suffered from secondary symptoms, and 12.50 from chancres only. From these observations he concludes that syphilis is such an important factor in the etiology of tabes dorsalis that scarcely any one who has not had syphilis or a chancre has a chance of becoming tabetic. As to the other factors in the etiology of tabes (viz., heredity, catching cold, fatigue, sexual excesses, and injury), he considers them of much less importance: of the 100 cases of the present series he gives in 36 cases syphilis as the only assignable cause, in 17 cases syphilis and cold, in 8 syphilis and fatigue, in 7 syphilis and excesses, in 2 syphilis and injury, in 15 syphilis, cold, and fatigue, in 4 syphilis, cold, and excesses, in 3 syphilis, fatigue, and excesses, in 1 syphilis, excesses, and injury as the assignable causes, and in 3 cases cold alone, in 2 cases fatigue alone, in 1 case excesses alone, and in 1 injury alone. Syphilis is thus the most frequent and important change of condition that favors the development of tabes, the other factors generally acting in company with syphilis.

The frequent paralysis of ocular muscles, the affection of the pupils, the presence of symptoms pointing to syphilitic affections of the cerebral nervous system (viz., hemiplegia, apoplexy, epileptiform attacks, and frequent headache); the presence of syphilitic affections of the skin, the mucous membranes, and the bones; the fact that in cases of tabes occurring late in life the patients have usually acquired syphilis late in life (in one case the patient acquired syphilis at the age of forty-eight, and became tabetic at the unusually late age of fifty-eight; in another case the patient, who had acquired syphilis at the age of thirty-eight, became tabetic at fifty); the relative frequency of syphilis and tabes in men and women (being in each disease as ten to one), the relative frequency of tabes and syphilis in women of the lower classes, the relative rarity of both in women of the higher classes, these facts Erb considers of great importance in assigning syphilis as the most important factor in the etiology of tabes. The occurrence of previous syphilis in tabetic women he considers not at all infrequent, for of 13 cases of tabes in women, 6 had a clear history of syphilis, 4 had no history, and in 3 cases the history was doubtful. From these statistics Professor Erb holds that syphilis is one of the most important, if not the most important, cause of the occurrence of tabes. That tabes is a specific disease, a late manifestation of syphilis, he does not consider to be proved, though he thinks it extremely probable.—*Medical Times and Gazette.*

RECENT INVESTIGATION ON THE BLOOD.—The Royal Academy of Medicine of Turin has unanimously awarded the Riberi prize of twenty thousand francs (four thousand dollars) to Professor Bizzozero for his researches on the "Physiopathology of Blood," the subject proposed by the Academy. The commissioners of award received several essays; those of Wharton Jones, Norris, Hayem, and Bizzozero were considered to deserve special consideration. The last two were assigned the first rank. The most important matter in both of these is the investigation of the third morphological element of the blood (Hayem's hæmatoblasts). The commissioners, all well-known *savants*, judged that Hayem did not completely demonstrate that the red globules are derived from the hæmatoblasts. Bizzozero solves the important problem of the origin of the red globules, determines the relation of the hæmatoblasts to coagulation, and throws new light on the formation of thrombi. His memoir was therefore deemed the more important, and to Bizzozero, accordingly, the very valuable award has been made.—*Science.*

BORACIC ACID.—Dr. Squibb writes of boracic—or more properly, according to the nomenclature of the late Pharmacopœia, *boric*—acid, as follows: If the powder be needed, as is generally the case, it should be specified

in the prescription. The powder should be very fine, and should be white and light, and entirely free from particles when rubbed between the finger and thumb, feeling very like powdered soap. It is only such powder that answers well in eye-surgery or general surgery for dressings, and solutions are also best made from it. A saturated solution contains about nineteen grains to the ounce, and from ten grains in the ounce to saturation it is used as an eye-wash or to granulating and suppurating surfaces. It is a very bland and soothing application, both in powder and solution, relieving irritation and arresting suppuration. It is a potent antiseptic, much less expensive than salicylic acid, and it is odorless and more easily managed than carbolic acid. It is probably better than either to preserve hypodermic solutions. In surgical dressings it has the great advantage over carbolic acid of not being irritant or poisonous. But, not being volatile, it does not deodorize the air.—*Ephemeris.*

SUBSOIL WATER AND TYPHOID FEVER.—Some researches have lately been made by M. Tessier, of Lyons, with a view to test the strength of Pettenkofer's position. As our readers know, Pettenkofer believes that there is a close relationship between the fall in the level of the subsoil water and the rise in the curve indicating the rate of mortality from enteric fever and cholera. M. Tessier does not confirm the hypothesis of Pettenkofer. It was shown that the level of the ground water fell and rose with the waters of the Rhone. The other factor was obtained from the statistics of the hospital at Lyons. From a comparison of the curves indicating the amount of ground water and the death-rate from enteric fever it came out that the latter was directly proportional to the former. On the other hand, the investigation of three hundred to four hundred cases of typhoid fever has allowed Tessier to establish the fact that the sufferers had drunk of the water of the (surface) wells, and that those inhabitants who used water directly from the Rhone had been spared the disease.—*Lancet.*

SUBCUTANEOUS LIGATURE OF ULCERATING EPITHELIOMA.—In a case of repeated and exhausting hemorrhages from an ulcerating cancer of the mammary gland, Prof. Nussbaum applied a subcutaneous ligature, drawn so tightly as to strangulate the growth. The bleeding was at once arrested, but the effects upon the malignant growth were remarkable: it shrunk to one-fourth of its former size and began to cicatrize. The same principle, by another method, was subsequently carried into operation. The base of an ulcerating epithelioma was girdled by an incision through the skin, made with the thermo-caustic knife. The object attained in each case was a partial interruption of the arterial and nervous supply to the affected area, and the progress of the patients was so satisfactory as to call forth Prof. Nussbaum's approval and endorsement. He recommends a more extended trial of this method, especially where there is bleeding.

EASY METHOD OF POSTERIOR RHINOSCOPY.—The difficulty of posterior rhinoscopy in some cases, owing to unusual length and breadth of the uvula, or narrowness of the space between the anterior pillars of the fauces and the posterior wall of the pharynx, may be overcome by passing a piece of rubber cord or tape along the floor of the nostril on each side, over the uvula, and bringing it out through the mouth, tying the ends together in front, making some traction upon the soft palate so as to draw it forward. Mr. Walsham, in a communication to the *Lancet* (July 28), acknowledges the above expedient as being of American origin, but recommends red rubber tubing as possessing special advantages for the purpose, being non-irritating and requiring no instrument in its introduction.

BENZOIC SULPHINIDE.—In connection with an investigation upon the hydro-carbons of the coal-tar group, it was discovered by C. Fahlberg that a certain compound obtained by the oxidation of toluene-sulphamide with potassium permanganate tasted sweet. It was found that this is not poisonous in doses of two or three grammes, and is excreted by the urine. As it is intensely sweet, it has been recommended to sweeten glucose. It forms salts with any carbonate of the alkalies, alkaline earths, or metals, all its compounds having a sweet taste. It is, however, not an acid, properly speaking, but belongs to the class of sulphinides; it dissolves readily in alcohol and in hot water, less so in cold water.—*Proceedings of the Franklin Institute, Philadelphia; Scientific American.*

THE DANGER OF OPERATING FOR HYDROPNEUMOTHORAX IN PHTHISICAL PATIENTS.—At the meeting of the Hamburg Medical Society in October, 1882 (*Deutsche Med. Woch.*), Herr Bülau represented the danger of operating in cases of hydropneumothorax in phthisical patients. He considers that the pressure of the fluid in the pleural cavity prevents the advance of tuberculous processes in the lungs, and that they go on increasing rapidly when the pressure is suddenly removed.

In the discussion which followed at the next meeting, in November, Herr Curschmann recommended operative interference when the presence of air or fluid in the pleura became too great, especially in cases where a valvular opening had existed into a bronchus. —*London Medical Record.*

ADONIDIN.—Adonis vernalis contains a glucoside which has been employed as a substitute for digitalin, which it resembles in its physiological and therapeutical effects.

Adonidin is furnished in the form of an amorphous powder, of a bitter taste, soluble in alcohol, much less so in ether or water. It is claimed to be free from a cumulative action, but more experiments are needed to establish its real value in medicine.

THE NERVE-CENTRES FOR UTERINE CONTRACTIONS.—Dr. Dembo claims to have discovered the ganglia concerned in the production of contractions of the uterus. He says they are situated in the anterior wall of the vagina, and are independent of the spinal cord.—*Centralbl. f. Gynäkol.*, August 11, 1883.

MISCELLANY.

THE COUVREUSE, OR MECHANICAL NURSE.—After two years' trial, says the *Lancet*, the *couvreuse* has proved so decided a success that a brief description of this ingenious contrivance may be desirable. It was in 1878 that Dr. Tarnier, when visiting the apparatus devised by M. Odile Martin for artificially hatching and rearing chickens, at the Jardin d'Acclimatation, suggested that a similar method might be applied with advantage to infants, especially in cases of premature birth. Two years elapsed, however, before any attempt was made to carry out this proposal; but in the course of the year 1880 a *couvreuse* was made and brought to the hospital of the Maternité. This is a plain wooden case or box measuring about two feet eight inches by two feet four inches, and two feet four inches in height. The box has a double covering, the space between being filled with sawdust to retain the heat, and is divided into two parts. The lower half contains a reservoir which holds about sixty litres of water, and is fed by a patent boiler that stands outside the box and is warmed by an oil lamp; or hot water may be used without recourse to the lamp. The upper portion of the box forms a warm chamber, where a little basket or cradle is placed large enough to hold two infants. From an opening at the side, this cradle may be withdrawn, while the top of the box has a double glass covering, so that the children and the thermometer lying by their side can be constantly watched. If the water used in the first instance is cold, it takes a long time to attain the required temperature; but once this is done, the lamp need only be relit three or four times during the course of the day. It is best to warm the apparatus while the infants are being fed or washed. The temperature within the *couvreuse* is generally maintained at 86° F., and, though the contrast on withdrawing the child to be fed or washed is very great, amounting often to 30° F., colds are not so frequent as among the infants nursed in the ordinary manner. Altogether, the experiment is considered so successful that it is proposed to supply all the hospitals of France with a *couvreuse*, and there is every reason to anticipate good results from this measure. Nor is this all. A small portable *couvreuse* is now about to be tried which could be carried by hand from house to house. After this we shall probably have perambulators constructed on the same model. In conclusion, we should remark that though no very careful experiments have been made with respect to the ventilation within the *couvreuse*, yet this is evidently sufficient. Apertures are made in the lower portion of the box, the fresh air travels over the hot-water reservoir, and is thus warmed before it reaches the child. The very great difference of temperature within the *couvreuse* insures a constant current of air, though the child is protected by its cradle and clothes from any draught.—*New York Medical Journal.*

AMERICAN PUBLIC HEALTH ASSOCIATION.—The American Public Health Association will hold its eleventh annual session at Detroit, Michigan, commencing Tuesday, November 13, 1883, and ending Friday, November 16.

The subjects which have been chosen for special consideration at that time are:

1. Malaria.—Its etiology and the methods for its prevention in localities or in persons; its American history; its specific particles; its origin; the conditions of its pervasion; its laws of extension, etc.

2. Foods.—Their adulterations; healthy or deleterious modes of preservation, and the function of legislation in regard to them. Ascertained facts as to adulterations in this country. Facts as to canned goods, condensed milk, artificial butter and cheese, prepared meats, etc.

3. Vital Statistics.—Methods and results; defects apparent. How far foreign modes of tabulation are to be followed. Systems of collection and classification. Race vitality and the care of population as indicated by statistics.

4. The Control and Removal of all Decomposable Material from Households.—The mechanical laws, constructions, and appliances relative thereto. The construction of all inside pipes and their connections, their traps, and siphonage, flushing, ventilation. How they shall be connected with out-door receptacles, and yet be free from ill effect.

Methods and systems of physical education, drill, etc., feasible in the school-room, will be discussed. While papers of merit on other topics are by no means excluded, it is believed wise to concentrate the preparation of papers and discussion upon these topics.

The Executive Committee insists that a synopsis of the papers to be offered, and statement of the time required for reading, be sent to the Secretary by October 15, and that the paper complete be in the hands of

the Secretary at least three days before the meeting, having been sent by mail or express either to his office at Boston, or care of Dr. William Brodie, Detroit, Michigan, after November 9.

The Executive Committee feels warranted in saying that the meeting promises to be one eminently inviting and profitable, and urges the attendance and co-operation of physicians, engineers, architects, teachers, and all those interested in the advancement of public health and physical well-being.

Inquiries of a local character may be addressed to William Brodie, M.D., Chairman Local Committee, Detroit, Michigan.—*The Medical Age.*

AMERICAN GYNÆCOLOGICAL SOCIETY.—The eighth annual meeting of the American Gynæcological Society was held in Philadelphia, at the hall of the College of Physicians, on Tuesday, Wednesday, and Thursday, September 18, 19, and 20. Papers were read on "Superinvolution of the Uterus," by Dr. Joseph Taber Johnson, of Washington; "The Importance of Cleanliness in Surgical Operations," by Dr. R. Stansbury Sutton, of Pittsburg, Pa.; "Hot Water in Secondary Hemorrhage after Pelvic Operations," by Dr. Albert H. Smith, of Philadelphia; "Some Points connected with the Subject of Dysmenorrhœa," by Dr. C. D. Palmer, of Cincinnati; "An Unusual Form of Abdominal Tumor—Three Cases," by Dr. Thaddeus A. Reamy, of Cincinnati; "Is Extirpation of the Cancerous Uterus a Justifiable Operation?" by Dr. A. Reeves Jackson, of Chicago; "A Biographical Sketch of Dr. Nathan Smith, Founder of the Dartmouth Medical College" (being the President's Address), by Dr. Gilman Kimball, of Lowell, Mass.; "A Study of the Etiology of Perineal Laceration, with a New Method for its Proper Repair," by Dr. Thomas A. Emmet, of New York; "The Management of Accidental Puncture and Other Injuries of the Gravid Uterus as a Complication of Laparotomy," by Dr. Charles Carroll Lee, of New York; "Congenital Fissure of the Female Urethra with Exstrophy of the Bladder," and "Menstruation after Extirpation of the Ovaries," by Dr. Henry F. Campbell, of Augusta, Ga.; "Remarks on Chronic Abscess of the Pelvis," by Dr. William H. Byford, of Chicago, and others. A full report of the sessions will appear in our next issue.

BUTTERINE.—Messrs. Tidy and Wigner have recently reported to the Society of Public Analysts the results of some experiments on the action of the mammary tissue of the cow on mutton fat, which tend to show that some ferment therein contained possesses the power of assimilating these fats more or less to those of butter, by converting the insoluble into soluble fatty acids, and doubtless milk itself, containing, as it does, epithelium and other derivatives from the mammary ducts, contains also some of the ferment in question. Oleomargarine contains more olein and less stearin than the fat from which it is made, the higher melting-point of the stearin permitting of its separation under moderate pressure and heat; but it would seem that whether the inventor of butterine (M. Mège) was quite conscious of what he was doing, or not, the incorporation of a certain quantity of milk with the oleomargarine brings about those changes in the fatty acids which Tidy and Wigner obtained by means of mammary tissue or its alcoholic extract, and which very probably take place in the gland as a physiological process in the natural secretion of milk, analogous to the conversion in the stomach of albumen into peptones.—*Medical Times and Gazette.*

DANGER LURKING IN SODA-WATER.—The public analysts of Montreal and Toronto, Drs. Edwards and Ellis, have been examining samples of soda-water, and report that in a majority of cases lead and sometimes copper is present. Dr. Edwards examined twelve samples purchased in Montreal and found lead or copper in ten of them. Five contained both lead and copper, and five contained lead only. In some samples only "traces" of the metals were found, while in others the water was "largely impregnated" with one or both of the metals. Dr. Ellis in twelve samples of Toronto soda-water found only three which were free from lead. No mention is made of the presence of copper. The quantity of lead varied from .07 of a grain to .5 of a grain to the gallon, the average of nine samples being .32 of a grain. All of the above samples were taken from fountain cisterns, bottled soda-water being invariably found free from metallic impurities.—*Sanitary Engineer.*

[This is in confirmation of an article recently published in these columns by Dr. Hays, of Pittsburg, and justifies his remarks.]

ORIGIN OF THE CHOLERA EPIDEMIC.—A very interesting report has been published by Chaffey Bey as to the origin of the outbreak at Damietta. After a careful analysis of all the circumstances of the case, he arrives at the conclusion that the cholera was not imported, but broke out spontaneously on account of the condition of the river and city, which this year presented conditions similar to those to be found on the banks of the Ganges when the epidemic made its appearance. The great fair at Damietta attracted a crowd of fifteen thousand people, who for eight days lived on foul water and decayed fish.—*British Medical Journal.*

THE POLYCLINIC:—not the first time, by twenty centuries!—The following is in the *Medical Times and Gazette* of April 7, 1883, taken from the *Lyon Médical:* "'The little son of my porter having fallen ill, I inquired about him, and learned that he was being attended by a doctor who lived a long way off,

although one resides on the premises. Expressing my surprise, the father said, 'Well, what is to be done? M—— is, perhaps, a good doctor, but I have no confidence in him.' How so? 'Why, you see,' replied the porter, lowering his voice, 'he gives advice gratis.'"

The following, from the Talmud, is more terse: "Asya dim'gan bim'gan shaveh," which is Arabic, and, being interpreted, meaneth, "The physician who cures for nothing is worth nothing." Similarly in "King Lear" we have,—

"*Kent.* This is nothing, fool."

"*Fool.* Then 'tis like the voice of an unfee'd lawyer."—*Medical Age.*

IN the Berlin Sanitary Exhibition there is exhibited a "people's kitchen." A wholesome meal is furnished at noon for six cents. In Berlin there are fourteen such kitchens, which are operated by an association patronized by the Imperial government. At these kitchens a meal consists of blood- and muscle-foods, and of alkaline salts and alcoholic stimulants. The meal at noonday, compounded on a scientific basis, must contain fifty-nine grammes of albumen, thirty-four grammes of fatty matter, and one hundred and sixty grammes of hydro-carbonaceous matter. The dinner, as served in a tin basin, consists of one litre of cooked vegetables, and a piece of meat which weighs seventy-five grammes. These kitchens are abundantly patronized, and the income is plentiful. —*Sanitary News.*

A NAIL EMBEDDED IN THE BRAIN.—In an autopsy on a patient dying in one of the Vienna hospitals there was found in his brain an iron nail covered with rust, which to all appearances must have been there since early childhood. The man was about forty-five years of age, a bookbinder, and always passed for intelligent. Negative popular evidence, however, is of but little value. The man, at regular intervals, had epileptic attacks, and post-epileptic mental phenomena while in the hospital.—*Medical Press and Circular.* [*Credat Judæus Apella!*]

SILK LIGATURES.—Prof. William Pancoast claims that a pure iron-dyed silk affords, after all, the best ligature, being thoroughly flexible, very strong, antiseptic, and as truly animal in its origin as catgut. He believes that white and colored silks are often irritant from drugs used in their preparation. Natural silk is yellow, not white. He claims that it is especially valuable in minute, delicate operations about the eyes, etc. It is furnished by Mr. Wm. Snowden, of this city.

CHLORAL HYDRATE AS A PURGATIVE.—B. Bonatti recommends chloral hydrate in combination with senna as a rapid and safe drastic cathartic. He prescribes,—℞ Infus. sennæ, f℥x; chloral hydratis, gr. xxiv to 1; syrupi, f℥j. M. With this he obtained an action where cotoin and jalap had failed.—*Deutsche Med. Zeitung; Pharmaceutical Gazette*, July, 1883.

ASSOCIATION FOR DISEASES OF THE RESPIRATORY ORGANS AND CLIMATOLOGY.—A meeting for the purpose of organizing a national "Association for Diseases of the Respiratory Organs and Climatology" will be held in the parlors of the Academy of Medicine in New York City (12 West Thirty-first Street), on Tuesday, September 25, at 10 A.M.

HARVARD MEDICAL SCHOOL.—The Medical Faculty of Harvard University will celebrate the centennial anniversary of the establishment of the school on October 17. Dr. Oliver Wendell Holmes will deliver an oration, after which the new building recently erected for the college on Boylston Street will be dedicated.

THE cholera epidemic in Egypt seems to be at an end. During its whole course—that is, in about three months—it has destroyed nearly thirty thousand lives.

THE well-known anatomist, Pacini, recently died at Padua.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM SEPTEMBER 1 TO SEPTEMBER 15, 1883.

BARTHOLF, JOHN H., CAPTAIN AND ASSISTANT-SURGEON.—Station changed from Fort Lapwai, I. T., to Vancouver Barracks, W. T. Paragraph 2, S. O. 123, Department of the Columbia. September 6, 1883.

SHUFELDT, ROBERT W., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for three months on surgeon's certificate of disability, with permission to leave the Department of the South. Paragraph 3, S. O. 204, A. G. O., September 5, 1883.

BANISTER, J. M., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to duty at Fort Adams, Rhode Island. Paragraph 3, S. O. 170, Department of the East, September 10, 1883.

WAKEMAN, W. J., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Sidney, Nebraska. Paragraph 2, S. O. 92, Department of the Platte, August 28, 1883.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE NAVY FROM SEPTEMBER 1 TO SEPTEMBER 15, 1883.

P. A. Surgeon OLIVER DIEHL detached from the Naval Academy and ordered to the U.S. steam-ship "Quinnebaug," European Station, per steamer of the 15th inst.

P. A. Surgeon FRANK ANDERSON detached from the U.S. steam-ship "Quinnebaug," on reporting of relief, and granted leave of absence for three months.

Surgeon G. S. BEARDSLEY and P. A. Surgeon GEORGE C. LIPPINCOTT detached from the "Galena," and placed on waiting-orders.

P. A. Surgeon H. T. PERCY detached from the Naval Hospital, Norfolk, and ordered to the U.S. steam-ship "Galena."

Surgeon GEORGE A. BRIGHT detached from the Naval Rendezvous, Philadelphia, on September 30, and ordered to the "Galena," October 1.

P. A. Surgeon R. A. URQUHART ordered to the "Alert" on October 6, and on the arrival of that vessel at Yokohama, Japan, to be detached and to report for duty at the Naval Hospital at that place.

P. A. Surgeon M. H. SIMONS to be detached from the Naval Hospital, Yokohama, Japan, on the reporting of his relief, and ordered to the U.S. steam-ship "Alert."